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In The Supreme Court of the United States

JERRY ISAACS,

Petitioner,

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI
WITH APPENDIX

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QUESTIONS PRESENTED

1. Can a court impose a blanket ban on all discovery merely and solely because the complaint "appears" to request benefits pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.*

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Jerry Isaacs ("Petitioner") respectfully petitions this honorable court for a writ of certiorari to review the June 13, 2008 decision of the United States Court of Appeals for the Fourth Circuit. That decision affirmed summary judgment to the insurer of a long term disability plan from which Petitioner sought benefits pursuant to the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. § 1132(a)(1)(B). The district court arbitrarily ordered a blanket ban on all discovery merely because Isaacs' complaint asserted a claim for ERISA benefits. In affirming, the Fourth Circuit sanctioned a departure so far from the accepted and usual course of judicial proceedings as to call for an exercise of this court's supervisory power.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit affirming the decision of the United States District Court for the District of South Carolina is unpublished and is reproduced in the Petitioner's Appendix. (Pet. App. 1a) The opinion of the district court granting summary judgment is unpublished and is reproduced in the Appendix. (Pet. App. 12a) The order of the district court imposing a ban on all discovery is unpublished and is reproduced in the Appendix. (Pet. App. 22a)

JURISDICTION

The Fourth Circuit denied a timely petition for rehearing and rehearing *en banc* on July 11, 2008. (Pet. App. 33a) This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS AND COURT RULES INVOLVED

ERISA, 29 U.S.C. § 1001(B) states, in relevant part:

> "It is hereby declared to be the policy of this chapter to protect . . . the interests of participants in employee benefit plans, . . ., by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts."

ERISA, 29 U.S.C. § 1132(a)(1)(B) states, in relevant part:

> "A civil action may be brought - -
> (1) by a participant . . .
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to certify his rights to future benefits under the terms of the plan;"

ERISA, 29 U.S.C. § 1132(e)(1) and (f) state, in relevant part:

> "(e) Jurisdiction.
> (1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil

> actions under this title brought by . . . a participant, . . . State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.
>
> (f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action."

Federal Rules of Civil Procedure 1 and 2 state, in relevant part:

> "Rule 1. Scope and Purpose of Rules.
>
> These rules govern the procedure in the United States district courts in all suits of a civil nature whether cognizable as cases at law or in equity ...
>
> Rule 2. One Form of Action.
>
> There shall be one form of action to be known as "civil action.""

Fed. R. Civ. P. 26(b)(1) states, in relevant part:

> "Parties may obtain discovery regarding any matter, not privileged that is relevant to the claim or defense of any party ..."

Fed. R. Civ. P. 56(c) states:

> "[Summary judgment] shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."

Fed. R. Civ. P. 56(f) states:

> "If a party opposing the motion shows by affidavit that, for specified reasons, it cannot present facts essential to justify its opposition, the court may:
>
> (1) deny the motion;
> (2) order a continuance to enable affidavits to be obtained, depositions to be taken, or other discovery to be undertaken; or
> (3) issue any other just order."

STATEMENT OF THE CASE

ERISA & Discovery

The Employee Retirement Income Security Act of 1974 ("ERISA") is a federal statute that regulates "employee benefit plans".[1] ERISA was enacted, in part, to "protect . . . the interest of participants in employee benefit plans . . . by providing for appropriate remedies . . . and ready access to the federal courts."[2] ERISA plan participants have the right to file a suit in a United States District Court to recover benefits.[3]

Any lawsuit for benefits under ERISA is a civil action subject to the Federal Rules of Civil Procedure which "govern the procedure in the United States District Courts in all suits of a civil nature whether cognizable as cases at law or in equity . . .".[4] Under the Rules of Civil Procedure "parties may obtain discovery regarding any matter, not privileged, that is relevant to the claim or defense of any party . . ."[5] The scope of allowable discovery "has been construed broadly to encompass any matter that bears on, or that reasonably could lead to other matter that could bear on, any issue that is or may be in the case . . . Discovery, itself, is

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[1] 29 U.S.C. § 1002(3).

[2] 29 U.S.C. § 1001(b).

[3] 29 U.S.C. § 1132(a)(1)(B), 29 U.S.C. § 1132(e)(1) and (f).

[4] Fed. R. Civ. P. 1.

[5] Fed. R. Civ. P. 26(b)(1).

designed to help define and clarify the issues."[6] The Court has held that "Discovery rules are to be accorded a broad and liberal treatment (intended to allow a party to inquire) into the facts underlying his opponent's case. Mutual knowledge of all the relevant facts gathered by both parties is essential to proper litigation. To that end, either party may compel the other to disgorge whatever facts he has in his possession. . . . Discovery procedure simply advances the stage at which the disclosure can be compelled from the time of trial to the period proceeding it, thus reducing the possibility of surprise."[7]

The Rules of Civil Procedure make clear that a court should not grant summary judgment without a party having a fair opportunity to conduct relevant discovery.[8] A motion for summary judgment cannot be granted without the opposing party having the ability to ". . . present facts essential to justify its position".[9]

ERISA affects millions of Americans. The Court recently recognized that it is estimated "that 1.9 Million beneficiaries of ERISA plans have

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[6] *Oppenheimer Fund, Inc., et. al. v. Sanders, et. al.*, 437 U.S. 340, 351 (1978).

[7] *Hickman v. Taylor, et. al.*, 329 U.S. 495, 507 (1947).

[8] Fed. R. Civ. P. 56(f). *See* also Fed. R. Civ. P. 56(c): "The judgment sought should be rendered if the pleadings, the discovery and disclosure materials on file and any affidavits show that there is no genuine issue as to any material fact . . .".

[9] *Id.*

healthcare claims denied each year" which result in hundreds of thousands of civil filings in federal court each year. *Metropolitan Life Insurance Company v. Glenn*, 128 S. Ct. 2343, 2350, 2351 (2008) (hereinafter "*Glenn*").

Glenn established clearly that a conflict of interest of an insurer is a factor to be considered when a court reviews a denied ERISA benefit claim under a deferential standard of review. The importance of a conflict can vary depending upon circumstances. The impact of a conflict may be slight, even "to the vanishing point", or it may be significant, such as, "where an insurance company administrator has a history of biased claims administration".[10]

Obviously, in order to be able to demonstrate the extent to which a conflict may have affected (or not affected) an insurer's objectivity or claim process requires some proof. As legal scholars have noted:

> "placing the burden on the plan participant to prove such a link without also allowing discovery and evidence outside the administrative record presents a near impossible task. A plan administrator may deny such a direct link (of financial bias) in an affidavit placed in the administrative record. However, it is easy to imagine that such plan administrator would find it difficult to maintain that denial under

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[10] *Id.*, 2351.

> cross-examination by a skillful trial lawyer."[11]

In the same article, Professors Bogan and Fu discuss the "consequential need for discovery and evidence outside of the administrative record",[12] noting that the very types of conflict of interest issues addressed by this court in *Glenn* would require "the claimant to pursue discovery and to introduce evidence outside of the administrative record in order to establish the existence of the identified factors. . . . There is no other way for the plan participant to establish a right to the burden shifting standard of review."[13]

For, "Absent discovery and evidence outside the administrative record, including the right to cross-exam witnesses, a plan participant remains unable to sift witnesses who may deny (incentives linked) to claim denials, thereby limiting the plan participant's ability to prove this factor in the serious conflict of interest analysis."[14]

Petitioner's Claim

Petitioner was a participant in an ERISA governed long term disability ("LTD") plan

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[11] Donald T. Bogan and Benjamin Fu, *ERISA: No Further Inquiry Into Conflicted Plan Administrator Claim Denials*, 58 Okla.L.Rev. 637, 668 (2005).

[12] *Id.*, at 643.

[13] *Emphasis added*; *Id.*, at 670.

[14] *Id.*, at 668.

established by his employer, Robert Bosch Corporation. The plan is insured by Metropolitan Life Insurance Company ("MetLife"). Pet. App. 82a. The plan document grants MetLife discretion to make final claim decisions. Pet. App. 87a. MetLife is a conflicted decisionmaker.

In February 2005, Petitioner filed a claim for "disability benefits". (Pet. App. 61a) Thereafter, Petitioner submitted various claim forms that did not delineate between short term disability ("STD") as opposed to long term disability ("LTD") and which, instead, generally referred only to "disability" benefits. Pet. App. 80a. However, at least one of the claim forms that Petitioner submitted specifically indicated that it could be used for "STD/salary continuance, LTD or unified disability STD/LTD". Pet. App. 75a. MetLife interpreted Petitioner's claim as being for STD only and on June 1, 2005, denied the claim advising that Petitioner had a right to appeal. Pet. App. 72, 73a. The denial letter was the first document provided to Petitioner that specifically referred to STD (as opposed to "disability" generally or STD and LTD together). Several days later, on June 6, 2005, Petitioner met with personnel in his employer's Human Resource Department and he was then provided certain forms which he was told were LTD claim forms. Petitioner completed and submitted these forms to MetLife. As Petitioner stated in an affidavit:

> ". . . I have completed or have had completed every form which MetLife or my employer, Robert Bosch, has ever provided me or told me I need to

> submit. I have never been told by MetLife or Robert Bosch that I did not file an LTD claim after I submitted the forms . . . which (were) provided to me in June 2005." Pet. App. 92a.

By November 2005, Petitioner had received no word from MetLife regarding either his STD or LTD claims and he was not quite sure how to proceed. Thus, Petitioner sought counsel.

On November 3, 2005, Petitioner's counsel wrote MetLife regarding the STD and LTD claims. Pet. App. 66a. Counsel was not certain if Petitioner had perfected his LTD claim so he wrote:

> ". . . If you could please forward any LTD claim forms or other documentation that needs to be completed in order to (perfect) the filing of that claim I would be most appreciative. If the LTD claim rolls over automatically after payment in full of the STD benefits then please just advise and I will proceed with the STD claim since, essentially, it will be considered to be the same claim. Either way is fine with me. Please advise as to how you prefer to handle the LTD claim. If there are any forms that need to be completed please send them to me." Pet. App. 70a.

It is undisputed that MetLife received counsel's November 3, 2005 letter.[15]

By January 9, 2006, neither Petitioner or counsel had received any acknowledgement from MetLife regarding counsel's November 3, 2005 letter. Accordingly, on January 9, 2006, counsel wrote:

> ". . . If I do not receive the documents in the next ten (10) days then, unfortunately, you will leave me no alternative but to assume that further attempts to exhaust administrative remedies are futile. I truly do not want to have to take the foregoing position and it is my sincerest hope that you will provide the documents I requested as soon as possible." Pet. App. 65a.

The January 9, 2006 letter was, also, indisputably received by MetLife.[16]

MetLife's claim log verifies that the recipient of counsel's letters faxed the correspondence "to legal". Pet. App. 63a. Neither Petitioner or counsel received any acknowledgement or response from

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[15] One copy of the letter in the administrative record in the lower courts demonstrates that it was received by facsimile by MetLife on November 3, 2005 at 17:21 a.m. A second copy of the letter does not bear the facsimile imprint at the top which is consistent with the two methods of transmission to MetLife, one by facsimile and the second by U.S. mail.

[16] The letter was contained in the administrative record in the lower court and was received via the only method of transmission, which was by facsimile.

MetLife. It was not a situation where the letters were lost in the mail. Instead, MetLife unquestionably received the correspondence, but simply failed to act upon them in any way except to forward them to "legal".

Unable to elicit any apparent action from MetLife, Petitioner filed a complaint in the United States District Court for the District of South Carolina on January 29, 2006 because futility seemed obvious.

In his second amended complaint, Petitioner asserted a claim for benefits pursuant to ERISA 29 U.S.C. § 1132(a)(1)(B) and, also, pled:

> "MetLife, who administers both the STD and LTD plans, denied Plaintiff's claim. Plaintiff appealed the denial, however, MetLife has failed to respond to Plaintiff's appeal and has taken longer than allowed under ERISA and, therefore, Plaintiff believes that further attempts to exhaust administrative

remedies would be futile and assumes the claim is denied." Pet. App. 95a.[17]

Two days after the filing of the relevant complaint, the District Court issued a "Specialized Case Management Order" (hereinafter "SCMO")[18] which stated:

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[17] MetLife's failure to act on Petitioner's LTD claim within the period required by 29 C.F.R. § 2560.503-1 allowed Petitioner to "deem" the claim denied. *e.g. Southern Farm Bureau Life Insurance Company v. Moore*, 993 F.2d 98 (5th Cir. 1993). Also, given MetLife's inaction Petitioner asserted "futility". The doctrine of "futility" is recognized in the Fourth Circuit as an exception to the general requirement that an ERISA claimant must exhaust all available administrative remedies before filing suit. *e.g. Makar v. Health Care Corp.*, 872 F.2d 80 (4th Cir. 1989). If futility is shown the court can conduct a *de novo* review of the claim. *e.g. Riggs v. A.J. Ballard Tire & Oil Co.*, 1992 U.S. App. LEXIS 31134 (4th Cir. 1992), unpublished.

[18] The issue raised by this petition is far reaching. The great majority of South Carolina's District Court Judges employ the SCMO for ERISA cases. The order has been issued in numerous cases. (For instance, *see Evans v. Eaton Corporation Long Term Disability Plan*, 2006 U.S. Dist. LEXIS 76322 (D.S.C. 2006), reversed and remanded by *Evans v. Eaton Corporation Long Term Disability Plan*, 514 F.3d 315 (4th Cir. 2008), where the District Court Judge noted "The parties have filed a joint stipulation and memorandum in support of judgment pursuant to the Court's specialized case management order for ERISA benefits cases." *Evans*, 2006 U.S. Dist. LEXIS 76322, *1. See also, *Belcher v. Verizon Wireless Short Term Disability Plan*, 2006 U.S. Dist. LEXIS 48861, *1 (D.S.C. 2006), "The parties have filed a joint stipulation . . . pursuant to the court's specialized case management order for ERISA benefit cases."; *Collins v. Quest Disability Plan, et. al.*, 2006 U.S. Dist. LEXIS 25620, *1 (D.S.C. 2006), same; *Gosnell v. US Life Insurance Company in the City of New York*, 2008 U.S. Dist. LEXIS 43483, *1 (D.S.C. 2008), same; *Elgin v. Aetna Life Insurance Company*, 2007 U.S. Dist. LEXIS 24527, *1 (D.S.C.

> "This case appears to request entitlement to benefits pursuant to Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et. seq.* In light of the claim for relief as set forth in the complaint, . . . the court orders as follows:" Pet. App. 22a.

Thereafter, the SCMO directs "No discovery shall be taken without permission of the court.". *Emphasis added*; Pet. App. 29a. The District Court did not adjourn any hearing or otherwise consider the propriety of a blanket prohibition on discovery in Petitioner's case before issuing the ban. Instead, the bar to discovery was imposed merely and solely because Petitioner's complaint referenced a claim for benefits under ERISA. After issuance of the SCMO, Petitioner filed a Motion to Lift the Stay on

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2007), same; and *Whitley v. Carolina Care Plan, Inc.*, 2006 U.S. Dist. LEXIS 93802, *9 (D.S.C. 2006), "The parties certify that they conferred . . . with respect to the matters contained in the specialized case management order.") The SCMO was also issued in *Donovan v. Eaton Corporation Long Term Disability Plan*, 462 F.3d 321 (4th Cir. 2006) and *Colucci v. Agfa Corporation Severance Pay Plan*, 431 F.3d 170 (4th Cir. 2005), among many other cases originating out of the District of South Carolina. The order imposing a blanket prohibition on discovery is issued in nearly every single ERISA case in the District of South Carolina. To the best estimate of Petitioner, approximately 534 ERISA cases filed in the District of South Carolina since January 1, 2006 have involved the SCMO. (Estimate based upon a search on PACER, http://pacer.psc.uscourts.gov/, for the District of South Carolina using search term "ERISA" and a date restriction of cases filed after January 1, 2006. Cases assigned to the Honorable C. Weston Houck and the Honorable Terry L. Wooten were excluded from the estimate because those Judges do not use the SCMO that automatically bans discovery in ERISA cases.)

Discovery. Pet. App. 56, 59, 60a. Petitioner only requested "to conduct limited discovery so as to be able to address . . . the important issue of the applicability of the doctrine of futility". Pet. App. 60a. Regretfully, the District Court never decided or even addressed Petitioner's discovery motion before granting summary judgment to MetLife and dismissing Petitioner's claim with prejudice.

Petitioner appealed to the United States Court of Appeals for the Fourth Circuit and, again, raised the discovery issue. Petitioner devoted a large portion of his brief solely to his right to do very limited discovery on the claim process. Pet. App. 45-55a. Petitioner cited the Fourth Circuit to numerous opinions from its sister circuits holding that an ERISA claimant has a right to conduct discovery regarding procedural issues pertaining to a benefit claim. (*Id.*)

Unfortunately, in affirming summary judgment, the panel wholly failed to address the important discovery issue. Pet. App. 1-11a.

That the inability to conduct discovery on the futility issue was directly fatal to Petitioner's cause is apparent from the panel statement:

> "His "bare allegations of futility are no substitute for the 'clear and positive' showing of futility . . . required before suspending the exhaustion requirement. (Citation omitted)" *Emphasis added*; Pet. App. 10a.

Petitioner had the burden to provide "clear and positive" evidence, and, yet, he was denied all means to do so.

Moreover, the panel affirmed the grant of summary judgment regarding the key issue of whether Petitioner had even actually filed an LTD claim by stating: ". . . the record is devoid of evidence that any other claim was filed pursuant to the LTD plan claim procedures." Pet. App. 9a.[19] Petitioner respectfully submits that it is difficult to fill an evidentiary void without the means to do so.

Petitioner filed a request for rehearing and rehearing *en banc* again raising the discovery issue. (Pet. App. 35-44a) On July 11, 2008, the Fourth Circuit denied his request via a form order and without comment. (Pet. App. 33a)

This petition followed.

REASONS FOR GRANTING THE WRIT

This petition presents the Court an opportunity to address an important and oft recurring issue by way of undisputed facts.

The issue is whether a plan participant asserting a claim for benefits under ERISA is allowed to conduct any discovery. This Honorable

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[19] Petitioner respectfully disagrees with the panel's finding that there was no evidence he had filed an LTD claim. In fact, at another portion of the opinion, the panel even acknowledges that there is a factual dispute regarding the forms Isaacs contends he was told were for his LTD claim. (Pet. App. 5a)

Court has previously been asked to address a similar issue. *See* petition in *Semien v. Life Insurance Company of North America*, 436 F.3d 805 (7th Cir.), *cert. denied*, 127 S. Ct. 53 (2006).[20] However, in *Semien*, the Court was presented the issue in a different context. There the District Court, with the Seventh Circuit affirming, actually considered the appropriateness of the discovery Semien sought and only after thoughtful consideration of the issues and law declined to allow the discovery. In Petitioner's case, the district court issued an order prohibiting all discovery before any specific discovery was even propounded simply because Petitioner's complaint appeared to claim benefits under ERISA.

Petitioner respectfully submits that the completely arbitrary and total ban on discovery imposed upon him by the District Court was a gross departure "from the accepted and usual course of judicial proceedings"[21] and when the Fourth Circuit affirmed it sanctioned that procedural abuse. Accordingly, Petitioner very respectfully submits that this matter calls for an exercise of the Court's supervisory power. Petitioner's case is not unique,

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[20] The "Question Presented" in the petition in *Semien* was framed: "Whether the Article III powers of a district court in adjudicating a civil action brought pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) are limited to conducting a review proceeding?" Petition for Writ of *Certiorari*, *Semien v. Life Insurance Company of North America*, p. i., Docket No. 05-1386. Although the petitioner in *Semien* "dressed" the issue up, it was, at its core, whether an ERISA plan participant can do discovery outside of the administrative record in connection with a benefit claim.

[21] Sup. Ct. R. 10.

but, is, instead, typical. The SCMO used in ERISA cases in the District of South Carolina has been used in hundreds, if not thousands, of cases over the years and will continue to be into the future.[22] Additionally, given this Court's recent decision in *Glenn*, limited discovery pertaining to procedural abuses by a conflicted insurer is clearly relevant and allowed per Fed. R. Civ. P. 26. This petition presents the Court undisputed, straightforward, and, simply said, perfect facts to address the narrow, but extremely important issue presented.

Certiorari should be granted.

I. The district court's blanket ban on discovery means that ERISA plan participants asserting benefit claims do not enjoy the privileges and protections of the Federal Rule of Civil Procedure 26 as do other civil litigants. Neither ERISA 29 U.S.C. § 1001 *et. seq.* or the Rules of Civil Procedure suggest or allow such an outcome.

An aggrieved ERISA plan participant can file a civil action for benefits pursuant to 29 U.S.C. § 1132(a)(1)(B) in the District Court.[23] The Federal Rules of Civil Procedure govern all civil actions filed in the District Court.[24] Under the Rules, a party to a civil action has a right to conduct "discovery

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[22] *Supra*, fn18.

[23] 29 U.S.C. § 1132(e) and (f).

[24] Fed. R. Civ. P. 1.

regarding any matter, not privileged, that is relevant to the claim or defense of any party . . .".[25] This court has recognized that "mutual knowledge of all of the relevant facts gathered by both parties is essential to proper litigation".[26] Accordingly, "discovery rules are to be accorded a broad and liberal treatment".[27] Yet, Petitioner was unquestionably denied his "essential" right as a civil litigant. Moreover, the denial of that right was accomplished in a most arbitrary manner. While discovery certainly has "ultimate and necessary boundaries"[28] those boundaries are usually imposed by courts only after consideration of relevant facts and law. For instance, in *Semien*, the claimant served discovery requests and later "sought to compel discovery in order to gather evidence about the relationship between (the insurer and its medical reviewers)."[29] There, the district court properly considered the merits of the motion to compel and then exercised its discretion to deny the plaintiff's motion by way of a considered opinion.[30] As the Seventh Circuit recognized, "The district court had significant discretion to allow or disallow discovery requests. This is a fact-specific determination and

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[25] Fed. R. Civ. P. 26(b)(1)..

[26] *Hickman*, 329 U.S. 495, 507.

[27] *Id.*

[28] *Oppenheimer Fund, Inc.*, 437 U.S. 340, 351.

[29] *Semien*, 436 F.3d 805, 807.

[30] *Semien*, 436 F.3d 805, 813. *See* also, District Court opinion denying plaintiff's motion to compel. 2004 U.S. Dist. LEXIS 6759 (N.D. Ill. 2004).

will not be overturned . . . absent a clear abuse of discretion."[31]

Petitioner was prohibited from doing discovery without any consideration by the district court of the relevant facts of his cause or the prevailing case law. The district court did not exercise any discretion. By its order filed September 20, 2006, the district court prohibited all discovery simply because "This case appears to request entitlement to benefits pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.*" Pet. App. 22a. The same blanket prohibition on discovery is issued in nearly every single ERISA case filed in the District of South Carolina and has been imposed in hundreds, if not thousands, of cases and continues to be used by that Court. Instead of conducting a meaningful review so as to be able to exercise its discretion on discovery issues, the South Carolina District Court imposes a blanket ban on all discovery only because a person has chosen to assert his right to file a benefit claim as a civil action. Neither the ERISA statute or the Federal Rules of Civil Procedure provide any basis for a conclusion that ERISA benefit claimants do not enjoy the same right to conduct relevant discovery as do other civil litigants. The District Court order imposing a blanket prohibition on all discovery is a clear denial of Petitioner's "essential" right to conduct discovery and is contrary to one of the primary purposes of the ERISA statute: to provide "ready access to the Federal Courts".[32] Surely,

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[31] *Emphasis added*; *Semien*, 436 F.3d 805, 813.

[32] 29 U.S.C. § 1001(b).

prohibiting ERISA benefit claimants from conducting any and all discovery is not consistent with "ready access" to the federal court system.

And, it is not as if Petitioner asked to do unfettered discovery. Petitioner sought only to do very limited discovery pertaining to legitimate procedural issues that had been specifically raised during his administrative review process and by his complaint. Petitioner specifically advised MetLife, before filing suit, that if it did not respond to counsel's letter that Petitioner would assume that further attempts to pursue the claim through MetLife would be futile. Pet. App. 65a. Petitioner's complaint specifically pled that further attempts to exhaust administrative remedies with MetLife were futile. Pet. App. 95a. Fourth Circuit case law recognizes "futility" as a legitimate exception to the exhaustion requirement for ERISA claims.[33]

As this court recognizes, relevancy for the purposes of FRCP 26 "has been construed broadly to encompass any matter that bears on or that reasonably could lead to other matter that could bear on, any issue that is or may be in the case".[34] Without question, the limited discovery that Petitioner sought, but was prohibited from doing, was relevant to his claim experience, complaint and the legal issues raised thereby.

The right to conduct limited discovery relating to procedural issues in an ERISA benefit case is even

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[33] *Supra, Makar*, fn17.

[34] *Oppenheimer Fund, Inc.*, 437 U.S. 340, 351.

more important because of *Glenn* which made clear that a conflict of interest and related procedural issues are relevant factors in reviewing an ERISA benefit claim denial. In *Glenn*, the Court recognized that multiple "factors" can be considered by reviewing courts. The Court provided examples of procedural information which might be relevant to "a combination of factors method of review".[35] How else can the parties to a civil action gather evidence necessary to address the various factors without some ability to conduct limited discovery? The answer is: "they cannot". As the esteemed Professors Bogan and Fu point out, "Placing the burden on the plan participant to prove (procedural points) without also allowing discovery and evidence outside of the administrative record presents a near impossible task."[36] Yet, that "impossible task" is exactly what faced Petitioner from the point of issuance of the SCMO by the District Court. Making matters more egregious is the fact that not only was Petitioner denied the right to conduct all discovery, but the denial was purely arbitrary. At the very least, Petitioner had the right to propound his discovery to, then, have his requests meaningfully considered by the court. Petitioner was prevented from even propounding any discovery!

Every Circuit Court, except the Fourth and Tenth, has recognized an ERISA claimant's right to do limited discovery relating to procedural issues. Wisely, the First Circuit in *Liston v. Unum Corporation Officers Severance Plan, et. al.*, 330 F.3d

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[35] *Glenn*, 128 S. Ct. 2343, 2351.

[36] Bogan and Fu, *supra*, fn11.

19 (1st Cir. 2003), held: "We have declined in cases like this one to adopt an ironclad rule against new evidence. For example, discovery may be needed because . . . certain kinds of claims - - e.g., proof of corruption - - may in their nature or timing take a reviewing court to materials outside of the administrative record."[37]

The Seventh Circuit in *Semien* recognized that discovery regarding procedural abuses relating to an ERISA claim may sometimes be necessary and adopted a logical approach in weighing whether discovery should ensue.[38]

> "Although discovery is normally disfavored in the ERISA context, at times additional discovery is appropriate to ensure that plan administrators have not acted arbitrarily and that conflicts of interest have not contributed to an unjustifiable denial of benefits. In these exceptional cases, where a district court allows limited discovery based upon what appears to be a sustainable allegation, the district court must monitor discovery closely. In this supervisory role, the district court should employ all available tools, including the imposition of Rule 11 sanctions against those who would abuse the discovery process.

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[37] *Liston*, 330 F.3d 19, 23.

[38] In fact, Petitioner urged the Fourth Circuit to adopt the Seventh Circuit approach to no avail.

Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate. *See Bruch*, 489 U.S. at 115 (a conflict of interest is a factor to be considered when reviewing a plan administrator's denial of benefits); *see also Van Boxel*, 936 F.2d at 1053 (less deference is appropriate where a trustee's impartiality can be fairly questioned). A claimant must demonstrate two factors before limited discovery becomes appropriate. First, a claimant must identify a specific conflict of interest or instance of misconduct. Second, a claimant must make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination. *See Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 932-33 (E.D. Tenn. 2004) ("Where . . . an ERISA plaintiff comes forward with a reasonable basis to believe that this conflict of interest has solidified in conscious, concrete policies, procedures, and practices to promote the company's financial welfare at the expense of a full and fair evaluation of the plaintiff's claim for benefits, then the plaintiff should be allowed to conduct limited discovery to determine whether such policies, procedures, and practices do

> actually exist and, if so, to what extent they interfered with the fair review of the plaintiff's claim for benefits. This information would certainly be relevant to the Court when conducting its review of the decision to deny benefits."[39] [40]

Liston quoted to *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1971).[41] This Court too cited *Overton Park* in *Glenn*.[42] In *Overton Park*, the Court recognized that sometimes "testimony" explaining the decisions of administrative officials might be necessary.[43] As the Court recognized in *Glenn*, an ERISA benefit claim is directly analogous to an administrative agency decision, and for the same reasons that it may sometimes be necessary to take testimony from

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[39] *Emphasis added, Semien*, 436 F.3d 805, 814, 815."

[40] *See*, also, *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 395 (3d Cir. 2000), where the court held "a District Court may take evidence regarding the conflict of interest, and ways in which the conflict may have influenced the decision, and then determine whether, considering the conflict, the decision was 'arbitrary and capricious'." *See*, also, *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163 (2d Cir. 2001), *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346 (5th Cir. 2004), *Wilkins v. Baptist Healthcare System, Inc., et. al.*, 150 F.3d 609 (6th Cir. 1998), *Farley v. Arkansas Blue Cross & Blue Shield*, 147 F.3d 774 (8th Cir. 1998), *Tremain v. Bell Industries*, 196 F.3d 970 (9th Cir. 1999), and *Moon v. American Home Assurance Company*, 888 F.2d 86 (11th Cir. 1989).

[41] *Liston*, 330 F.3d 19, 23.

[42] *Glenn*, 128 S. Ct. 2343, 2351.

[43] *Citizens to Preserve Overton Park, Inc.*, 401 U.S. 402, 420.

administrative officials, there is also sometimes a need to conduct discovery (and, perhaps, present testimony) regarding procedural issues with ERISA claims.

In *Glenn*, the Court made clear the need to protect ERISA plan participants from conflicted decisionmakers. The court expressed particular concern about "biased" claim processes. Yet, the imposition of a blanket ban on all discovery wholly prevented Petitioner from gathering any evidence relating to MetLife's obvious and undisputed procedural malfeasance (and its root cause). So, petitioner was unable to meaningfully address the concerns that were at the heart of *Glenn*. *Glenn* is rendered null, in the District of South Carolina, if a plan participant has no means by which to address the factors enunciated as being relevant (in appropriate cases). There is no suggestion anywhere in the text of the ERISA statute or in the Federal Rules of Civil Procedure to the effect that ERISA plan participants do not enjoy the protections and rights afforded by Fed. R. Civ. P. 26. In fact, as this court has pointed out on numerous occasions, ERISA is founded in trust law.[44] Certainly, discovery has been generally available in trust law and there is nothing in the history of trust law to suggest that ERISA plan participants asserting a claim for

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[44] *See Glenn*, 128 S. Ct. 2343, 2347.

benefits should not have the same right to conduct discovery on procedural issues.[45]

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[45] *See Nagele v. E.D.S. Corp.*, 193 FRD 99, 103, 104 (W.D. NY 2000) for an excellent discussion of trust law cases and the analogy to the right to conduct discovery in an ERISA case. In a *pre-Glenn* opinion, the district court judge, in *Nagele*, recognizing a standard nearly identical to the Court's holding in *Glenn* stated: "In reviewing a fiduciary's decision, a district court "must consider 'whether the decision was based on a consideration of the relevant factors.'". *Nagele*, 193 F.R.D. 94, 103, 2000 U.S. Dist. LEXIS 6564, **26. The court then reasoned, in allowing discovery, that:

> "Nor does the arbitrary and capricious standard as applicable to reviewing actions by a plan trustee, in exercising discretionary authority, itself preclude the potential need for discovery. First, it is familiar law that discovery is available where a beneficiary challenges a trustee alleging improper administration of a trust for the beneficiary's benefit. *Bouis v. Warren*, 112 So. 2d 283, 284 (Fla. Ct. App. 2d Dist. 1959) (use of interrogatories upon establishing right to accounting on claim of constructive trust); *Vasoli v. Vasoli*, 100 N.H. 200, 122 A.2d 533, 534 (N.H. 1956) (disclosure of source of assets during deposition recognized as proper upon establishing *prima facie* cause of constructive trust); *Barnett v. Ross*, 333 Pa. 510, 3 A.2d 923, 925 (Pa. 1939) (in action for breach of implied trust by fiduciary, plaintiff beneficiary may seek bill of discovery in equity to support claim of existence of trust and misconduct of alleged trustee); *Union Trust Co. v. Superior Court*, 11 Cal. 2d 449, 81 P.2d 150 (Cal. 1938) (directing discovery of books and records used by trustee upon counterclaim of breach of trust by beneficiary); *Alabama Girls' Industrial School v. Reynolds*, 143 Ala. 579, 42 So. 114, 115 (Ala. 1904) (in an action between trustee and beneficiary "a trustee is bound to render every necessary information required of him . . ."); *see also* Annotation, Right of Beneficiary or Claimant of Estate to Inspect Books and Papers of Trustee or Executor, 118 A.L.R. 269 (1939); *cf.*, N.Y. Surr. Ct. Proc. Act §

Glenn directed the lower courts to *Universal Camera Corp. v. National Labor Relations Board*, 340 U.S. 474 (1951). (*Id.*, 2352) In *Universal Camera*, the Court stated:

> "The direction in which the law moves is often a guide for decision of particular cases, ... However halting its progress, the trend in litigation is towards a rational inquiry and to truth,

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2211.2. (McKinney's 1997) ("fiduciary may be examined under oath by any party to the proceeding . . . as to any matter relating to his administration of the estate."); *Pardee v. Mutual Benefit Life Ins. Co.*, 238 A.D. 294, 265 N.Y.S. 837, 842 (App. Div. 4th Dep't 1933) (examination before trial limited to plaintiff's capacity as testamentary trustee). Significantly, the cases recognizing the availability of discovery against a fiduciary do not distinguish between disputes involving discretionary or nondiscretionary decisions, as permitted under the trust instrument, by the fiduciary, as relevant to whether discovery should be granted. As the Supreme Court in *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570, 86 L. Ed .2d 447, 105 S. Ct. 2833, *rehrg denied*, 473 U.S. 926 (1985) stated, "[in enacting ERISA, Congress] invoked the common law of trusts to define the general scope of their [trustees and other fiduciaries acting under the plan] authority and responsibility." *See also Firestone v. Bruch, supra*, noting that ERISA "abounds with the language and terminology of trust law." *Bruch, supra*, at 110. Here, it is undisputed that the plan constitutes a trust for Plaintiff's benefit under ERISA. Therefore, to the extent ERISA is founded upon principles of trust law, permitting discovery in relation to judicial review of the conduct of fiduciaries is consistent with such principles." *Id.*, 193 F.R.D. 94, 103, 104, 2000 U.S. Dist. LEXIS 6564, **28, **29, **30, **31.

> in which the tribunal considers everything "logically probative of some matter requiring to be proved . . .". Machinery for discovery of evidence has been strengthened; the boundaries of judicial notice have been slowly, but perceptively enlarged."[46]

Petitioner very respectfully submits that the District Court's imposition of an arbitrary and blanket ban on all discovery halts and, in fact, outright reverses "the direction" set by *Glenn*. To impose a blanket ban on discovery simply because a complaint asserts a claim for benefits under ERISA improperly denies plan participants their "essential" right to relevant discovery relating directly to the factors referenced in *Glenn* as being relevant. Accordingly, Petitioner respectfully submits that the District Court "so far departed from the accepted and usual course of judicial proceedings", and that the Fourth Circuit has sanctioned such departure, so as to call for "an exercise of this Court's supervisory

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[46] *Universal Camera Corp.*, 340 U.S. 474, 497.

power".[47] Moreover, the blanket ban on all discovery imposed by the District Court and sanctioned by the Fourth Circuit is contrary to every Circuit Court which has considered the issue, all of whom recognize that in certain circumstances limited discovery relating to ERISA claim procedures is allowed. This fundamental principle is even more clear in light of *Glenn*.

II. The Petitioner and the Fourth Circuit should be allowed to address the issues raised by this petition in light of *Glenn*.

At the least, Petitioner very respectfully asks that this Court exercise its practice "of *granting* certiorari, *vacating* the judgment below, and *remanding* for further proceedings in light of intervening developments . . ." (GVR).[48] Clearly, *Glenn* was a significant intervening development. Just six days after the Fourth Circuit issued the opinion in Petitioner's case this Court issued its very

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[47] The Court has not been reluctant to grant certiorari where courts have departed "from settled federal practice". For instance, *see New York City Transit Authority, et. al. v. Beazer, et. al.*, 440 U.S. 568, 582 (1979). In the *New York City Transit Authority* case, the United States Court of Appeals for the Second Circuit effectively bypassed consideration of a statutory issue (*i.e.*, Title VII) to, instead, address "a question of constitutionality". The court there did not "condone this departure from settled federal practice" (*Id.*) and Petitioner respectfully submits that the court should, likewise, not condone the gross departure from federal practice in his case (namely, the district court quashing the essential right to conduct discovery as allowed by Fed. R. Civ. P. 26).

[48] *Thomas v. American Home Products, Inc.*, 519 U.S. 913 (1996).

important (and clearly relevant) decision in *Glenn*. Neither the parties or the Fourth Circuit had the benefit of *Glenn* in briefing or arguing the issue of Petitioner's request to do limited discovery pertaining only to the very types of procedural issues which this court specifically decided were relevant in *Glenn*.

The Fourth Circuit's view on discovery relating to procedural issues prior to *Glenn* could not be fairly said to be "in sync" with the majority of courts. In fact, in barely a month after *Glenn* was issued the Fourth Circuit's pre-*Glenn* view of discovery relating to conflict of interest issues was criticized by other courts. In *Hogan-Cross v. Metropolitan Life Insurance Company*,[49] the court rebuffed MetLife's argument that plaintiff could not do discovery on conflict of interest issues by criticizing the Fourth Circuit decision upon which MetLife relied. The court stated:

> "MetLife relies upon *Abromitis v. Continental Casualty Co.*, (261 F.Supp.2d 388 (W.D.N.C. 2003), *aff'd without consideration of the point*, 114 Fed. App'x. 57 (4th Cir. 2004)) for the proposition that compensation of an outside consultant is not relevant where the consultant was not the decision-maker. But *Abromitis* is not helpful, particularly in light of *Glenn*. It rested in the first instance on the Fourth Circuit's *pre-Glenn* view that discovery

[49] 2008 U.S. Dist. LEXIS 58027 (S.D.N.Y., decided July 31, 2008).

was seldom permissible where the scope of review is the arbitrary and capricious standard. It then relied upon district court cases that concluded that where, as here, a conflict of interest is apparent on the record, discovery as to the extent of the conflict is inappropriate.

This view would not have been persuasive to this Court even before *Glenn*. The ultimate question in these cases is whether the decision in question was arbitrary and capricious. In making that determination, the existence, nature, extent, and effect of any conflict of interest are relevant considerations.

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The categorical or nearly categorical view of *Abromitis* and the cases upon which it relied - - that discovery is seldom if ever permissible in these cases, at least if the existence of the conflict inherent in the plan administrator both determining claims and paying benefits is apparent on the record - - thus is blind to potentially important information that, at least in some cases, may be critical to the fair and informed review of benefit claims.

> Were there any doubt about this, *Glenn* removed it. It rejected special procedural or evidentiary rules and, in this Court's view, thus abrogated the limitations on discovery unique to ERISA cases that were imposed or applied by such cases as *Abromitis*.
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> Thus, the Court (in *Glenn*) made clear that not all conflicts are created equal. Their significance in any given case depends upon all of the circumstances, including those suggesting a higher or lower likelihood that the conflict affected the decision." *Emphasis added*; 2008 U.S. Dist. LEXIS 58027, *8, *9, *10

The Southern District of New York is correct. *Glenn* did not hold that reviewing courts should assign a fixed and constant value to the impact of any conflict of interest. Instead, *Glenn* makes clear that the significance of a conflict can vary based upon facts and how else can those facts be established but through the right to conduct relevant, albeit limited, discovery.

The Fourth Circuit's pre-*Glenn* view of discovery which was in effect when Petitioner's case was decided was clearly inconsistent with *Glenn*. Out of fairness to Petitioner and, also, to the Fourth Circuit Court of Appeals, both Petitioner and that honorable Court should have the opportunity to

address Petitioner's request to conduct discovery in the context of *Glenn*.

Accordingly, at the very least, Petitioner very respectfully requests that the court "GVR" his cause.

Isaacs respectfully requests that the Court grant his petition for *writ of certiorari*.

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APPENDIX

ENTERED June 13, 2008

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 07-1549

JERRY ISAACS,

Plaintiff - Appellant,

versus

METROPOLITAN LIFE
INSURANCE COMPANY,

Defendant - Appellee,

and

ROBERT BOSCH SHORT
TERM DISABILITY PLAN,

Defendant.

Appeal from the United States District Court for the District of South Carolina, at Charleston. David C. Norton, District Judge. (2:06-cv-00288-DCN)

Argued: May 15, 2008 Decided: June 13, 2008

Before NIEMEYER and DUNCAN, Circuit Judges, and Claude M. HILTON, Senior United States District Judge for the Eastern District of Virginia, sitting by designation.

Affirmed by unpublished opinion. Judge Duncan wrote the opinion, in which Judge Niemeyer and Senior Judge Hilton joined.

Robert Edward Hoskins, FOSTER LAW FIRM, LLP, Greenville, South Carolina, for Appellant. James Derrick Quattlebaum, HAYNSWORTH, SINKLER & BOYD, PA, Greenville, South Carolina, for Appellee.

Unpublished opinions are not binding precedent in this circuit.

DUNCAN, Circuit Judge:

Jerry Isaacs ("Isaacs") brought this action seeking a declaration of his entitlement to long-term disability ("LTD") benefits under an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132. The district court granted summary judgment in favor of defendant-appellee Metropolitan Life Insurance Company ("MetLife"), holding that Isaacs had not exhausted his administrative remedies because he failed to file an LTD claim within ninety days after his "date of loss," as required by the plan. We affirm, albeit for slightly different reasons than those given by the district court.

I.

Isaacs appeals the district court's grant of summary judgment in favor of MetLife. Accordingly, we review the facts in the light most favorable to Isaacs. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986).

Isaacs was employed by the Robert Bosch Corporation ("Bosch") and participated in the Robert Bosch LTD Plan (the "LTD Plan"). MetLife is the claims administrator for the LTD Plan. MetLife also serves as the administrator for a separate Bosch short-term disability ("STD") plan, and for Bosch employees' requests for leave under the Family and Medical Leave Act ("FMLA").

The LTD Plan detailed two methods through which a claimant could initiate a claim for LTD benefits. One option allowed a claimant to submit a notice of claim and supporting written evidence directly to MetLife. Under the second option, a claimant could give notice to MetLife by calling a toll-free telephone number, after which MetLife would send a claim form to be returned by the claimant with supporting written evidence to MetLife.

Isaacs stopped reporting for work at Bosch on February 10, 2005, for reasons that are beyond the scope of this appeal. On February 18, 2005, Isaacs initiated a telephonic claim for benefits. MetLife processed the call as a concurrent FMLA/STD claim and sent forms to Isaacs, which he completed.[1] Isaacs visited Dr. Arlene Olaisen, who evaluated Isaacs and completed an Attending Physician Statement on his behalf. Dr. Olaisen informed MetLife that she had not advised Isaacs to stop working, and that in her opinion Isaacs could safely perform his job duties while on his current medication. Citing Dr. Olaisen's statements, MetLife denied Isaacs's STD claim by letter dated June 1, 2005. In a separate letter, MetLife denied Isaacs's FMLA claim, citing his "fail[ure] to provide the required medical certification of a serious health condition." J.A. 142.

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[1] Isaacs points out that forms sent to him by MetLife referred generically to a "disability claim" or "disability benefits" and did not differentiate among FMLA, STD, and LTD benefits. See J.A. 147, 151.

On June 6, 2005, Isaacs contacted MetLife to ask "what was needed in order for the claim to be accepted." J.A. 65. MetLife advised Isaacs "that in order for the decision to be re-evaluated his physician would need to submit medical documentation to support his disability claim." Id. The same day, in a face-to-face meeting, Janice Woods ("Woods"), a Medical Supervisor with Bosch, provided Isaacs with forms that she indicated would be sufficient to initiate a claim for LTD benefits.[2] Isaacs took the forms to his doctor in July 2005, who completed them and later faxed a copy to MetLife. Isaacs also returned a copy of the completed forms to Woods and Bosch's head of personnel for the Plan, and was told by them "that these forms were all that was needed and that [he] would be contacted if anything further was required." J.A. 209.[3]

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[2] There is a factual dispute surrounding these forms. Woods asserts that she gave Isaacs a set of three Long Term Disability Claim Forms: an LTD Claim Form Employee Statement, an LTD Claim Form Employer Statement; and a "Long Term Disability Claim Form Attending Physician Statement." J.A. 231-43. By contrast, Isaacs alleges that the forms he received from Woods were limited to a generic four-page "Attending Physician Statement" that nowhere indicated that it pertained solely to LTD claims. J.A. 208-13. We accept Isaacs's view for purposes of resolving this appeal.

[3] Contrary to Isaacs's argument that these forms were intended to initiate an LTD claim, the forms faxed to MetLife by Isaacs's doctor--ostensibly the same forms returned to Bosch--included a cover page and authorization form with the claim numbers for Isaacs's STD and FMLA claims and several pages specifically referencing the FMLA claim. None of the faxed forms referenced an LTD claim. J.A. 120-37.

In October 2005, Isaacs retained counsel. On November 3, 2005, Isaacs's attorney wrote a letter to MetLife captioned, "Short-Term Disability Claim," and referencing Isaacs's STD claim number. J.A. 109-11. In direct contradiction to the caption, the first sentence of the letter reads, "Please be advised that I have been retained to represent [Isaacs] in connection with the appeal of your denial of his claim for long term disability benefits." J.A. 109 (emphasis added). After a detailed request for review of Isaacs' claim and a request for a copy of the administrative record, the letter's penultimate paragraph reads,

> The third purpose of this letter is with regard to my client's LTD claim. My client has been out long enough to where it is time to get her [sic] LTD claim in the works. If you could please forward any LTD claim forms or other documentation that needs to be completed in order to prefect [sic] the filing of that claim I would be most appreciative. If the LTD claim rolls over automatically after payment in full of the STD benefits then please just advise and I will proceed with the STD claim since, essentially, it will be considered to be the same claim.

J.A. 110. MetLife did not respond to this letter. On January 9, 2006, counsel wrote another letter to MetLife, again referencing Isaacs's "Short-Term Disability Claim" and listing his STD claim number, explaining, "Please be advised that I am appealing

the denial of both Mr. Isaac's claim for short term disability and long term disability benefits. I wanted to clarify the foregoing in the event it was not clear [from the November 2005 letter]." J.A. 107. Counsel filed the complaint in this matter less than three weeks later, on January 29, 2006.

Isaacs's amended complaint named MetLife and the Robert Bosch Short Term Disability Plan as defendants and sought declarations of Isaacs's entitlement to LTD and STD benefits under 29 U.S.C. § 1132(a)(1)(B). Isaacs later dismissed the Robert Bosch Short Term Disability Plan as a defendant and dropped his STD claim from this case. Instead, Isaacs initiated a claim for STD benefits in state court. While Isaacs's federal claim was pending, Isaacs litigated the STD claim to settlement in state court.

Reviewing the LTD claim against MetLife, the district court held that Isaacs failed to file an LTD claim within ninety days after his "date of loss," as required by the plan, and that, as a result, he had not exhausted his administrative remedies. The court also rejected Isaacs's alternative argument that his failure to meet the exhaustion requirement was excused by the doctrine of futility. Accordingly, the court granted MetLife's motion for summary judgment. Isaacs appeals.

II.

We review de novo the district court's grant of summary judgment. See Ellis v. Metro. Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997). We will affirm the

district court's decision "if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). Again, we view the record and all reasonable inferences drawn therefrom in the light most favorable to Isaacs. See Williams v. Giant Food Inc., 370 F.3d 423, 428 (4th Cir. 2004).

A.

This appeal essentially distills to two somewhat interrelated arguments, which we discuss in turn. First, Isaacs asserts that he initiated an LTD claim through his February 18, 2005 phone call to MetLife but that MetLife prevented him from pursuing the claim by failing to send him forms necessary to perfect that claim; by not responding to his attorney's November 2005 and January 2006 letters; and by otherwise failing to act on his LTD claim. MetLife responds that Isaacs never actually filed an LTD claim and that it processed and ultimately rejected the only properly-filed claims--the STD and FMLA claims--based on insufficient evidence of disability.

Isaacs's argument ultimately implodes as it attempts to do two inherently contradictory things simultaneously. Isaacs fully pursued the claim he initiated on February 18, 2005 through the administrative process. Isaacs's attorney indicated in November 2005 that he understood that Isaacs's STD and LTD claims were one and the same, and in January 2006, referencing a single claim number,

that he was "appealing the denial of both Mr. Isaac's claim for short term disability and long term disability benefits." J.A. 107. Isaacs eventually litigated this claim to settlement in state court. Now, Isaacs would have it that MetLife precluded him from pursuing a claim for LTD benefits by not processing a separate LTD claim based on his February 18, 2005 telephonic claim.

Isaacs cannot have it both ways. The initial claim on which he now seeks to rely was denied due to Isaacs's failure to provide sufficient evidence of a disability.[4] His dismissal of the appeal in that regard and pursuit and settlement of the matter in state court places the denial of benefits on that claim beyond the scope of our review, and the record is devoid of evidence that any other claim was filed pursuant to the LTD Plan claims procedures. See J.A. 194 (describing the two methods for filing a claim under the LTD Plan).[5]

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[4] It is unclear how Isaacs believes he would have benefited had MetLife processed an LTD claim beginning on February 18, 2005. As Isaacs himself points out, "disability" is defined identically in the STD and LTD plans. Appellant's Br. at 8. Isaacs's failure to provide evidence of a disability therefore would likely have doomed his LTD claim just as it did his claim for STD benefits.

[5] The evidence leaves no doubt that on June 6, 2005, if not before, Isaacs knew that MetLife had not yet received from him documentation sufficient to initiate a claim for LTD benefits. See Isaacs Aff., J.A. 208 ("[At the June 6 meeting] I was told that I needed to file for long-term disability [benefits] and I replied that I did not have the forms."). It seems disingenuous for Isaacs to claim that he continued to labor under the illusion that an LTD claim had been filed on February 18, 2005 and remained pending.

B.

Isaacs also argues that his receipt, completion, and return of the forms Woods gave him on June 6, 2005 was the functional equivalent of filing a claim under the LTD Plan. We disagree. Aside from the February 18, 2005 claim discussed above, Isaacs has never properly initiated any other claim for benefits with MetLife. Moreover, the documents faxed by Isaacs's doctor referenced either the STD and FMLA claims or no claim at all. We therefore hold that the faxed forms were insufficient to initiate a claim under the LTD Plan.[6] Isaacs's attorney's subsequent letters were likewise insufficient either to initiate an LTD claim or to put MetLife on notice that Isaacs believed that such a claim existed separate and apart from his STD claim.

III.

Isaacs's actions have presented us with a record which includes neither a predicate finding of disability nor a completed claim for LTD benefits.

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[6] Isaacs argues, in the alternative, that his failure to exhaust his administrative remedies with respect to his LTD claim should be excused because, in light of MetLife's denial of his STD claim, any attempt to pursue the LTD Plan remedies would have been futile. We find that Isaacs failed to show that he was (or would have been) denied access to the claims procedures provided by the LTD Plan. His "bare allegations of futility are no substitute for the 'clear and positive' showing of futility . . . required before suspending the exhaustion requirement." Makar v. Health Care Corp. of Mid-Atlantic (Carefirst), 872 F.2d 80, 83 (4th Cir. 1989). We therefore find Isaacs's argument to be without merit.

We therefore have no basis on which to grant him the relief he seeks.

AFFIRMED

ENTERED June 8, 2007

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Jerry Isaacs,	)
	)
Plaintiff,	)
	)
vs.	)
	)
Metropolitan Life Insurance Co.,	)
	)
Defendant.	)
	)

C/A No. 6:06-CV-00288-DCN

ORDER and OPINION

This matter is before the court on plaintiff's motion for partial summary judgment and to lift the stay on discovery, and on defendant's motion for summary judgment or, in the alternative, to remand for further administrative consideration. Plaintiff seeks long term disability (LTD) benefits from defendant, which was the claim administrator for the ERISA-covered plan that plaintiff participated in. These motions ask whether plaintiff properly made a claim for LTD benefits and, if so, whether he has exhausted the administrative remedies with respect to that claim. For the reasons set forth below, defendant's motion for summary judgment is

granted because plaintiff did not make a claim for LTD benefits as required under the plan.

I. BACKGROUND

Plaintiff was employed by the Robert Bosch Corporation and participated in an employer-sponsored LTD plan. The parties agree the plan was covered by ERISA. Defendant served as the plan's claim administrator. Defendant also served as the claim administrator for two other programs: the Robert Bosch Salary Continuation Plan, which was not covered by ERISA, and Robert Bosch employees' requests for leave under the Family Medical Leave Act (FMLA). In addition to the LTD plan, plaintiff participated in the Robert Bosch Salary Continuation Plan, which provided short-term disability insurance.

The LTD Plan provided procedures that employees had to follow to make a claim for LTD benefits. The plan document stated the general method of filing a claim:

> The Policyholder [Robert Bosch Corp. in this case] should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

(Pl. Ex. A at 139.) The plan also provided that "both the notice of claim and required Proof should be sent to Us within 90 days of the date of a loss." (Id.) The plan then outlined a four step process by which the claimant could submit notice and the required proof: (1) calling defendant at the provided telephone number within 20 days of a loss; (2) defendant would then send a claim form, which should be received by the claimant within 15 days of the notice; (3) the claimant would then fill out the claim form and return it with the required proof; and (4) "[t]he claimant must give Us Proof not later than 90 days after the date of the loss." (Id.)

Plaintiff's last day at work was February 10, 2005. (Pl. Ex. A at 1.) Plaintiff submitted a telephonic claim to defendant for short-term disability benefits and FMLA leave on February 18, 2005. (Pl. Ex. A at 1.) Pursuant to that claim, plaintiff completed a form that waived medical confidentiality. Plaintiff also submitted a form completed by his doctor that described his medical condition. (Pl. Ex. A at 88-90.) That form was titled, "Disability Claim Attending Physician Statement."(Id.) On May 26, 2005, defendant denied plaintiff's request for FMLA leave for lack of medical evidence. (Pl. Ex. A at 87.) On June 1, 2005, defendant denied plaintiff's claim for short-term disability because plaintiff's doctor stated that plaintiff was capable of performing his job duties. (Pl. Ex. A at 84.)

On June 6, 2005, Plaintiff met with Any Anderson, head of personnel for the plan, and Janice Woods, Robert Bosch's medical supervisor. At that

meeting, plaintiff's employer provided the LTD claim forms. Plaintiff then alleges he took the forms to his doctor, who completed them, and faxed them to defendant. Plaintiff states he also took a copy of the completed forms to his employer, who said that was all he needed to do. (Pl. Ex. B.) Defendant has submitted the affidavit of a Bosch employee who was in that June 6, 2005, meeting with plaintiff. (Def. Ex. A.) She asserts plaintiff never returned the forms he was provided.

Plaintiff thereafter submitted additional forms competed by his physicians, which his doctors sent via fax. The first fax, sent on September 21, 2005, was an "Attending Physician Form" completed by an unknown doctor that referenced plaintiff's FMLA claim number. (Pl. Ex. A at 81-82.) The form is apparently incomplete and does not contain the name or signature of a doctor, although it does state "[t]he employee is unable to perform any kind of work."(Id.) The second fax, sent on September 22, 2005, contained another Attending Physician Statement signed by Dr. James Koon along with some of plaintiff's medical records. None of these forms or records mentioned LTD benefits. (Pl. Ex. A at 65-70.)

In November, plaintiff began attempting to deal with defendant through counsel. On November 3, 2005, plaintiff's counsel sent a letter via fax and U.S. Mail to defendant. (Pl. Ex. A at 54.) The letter addressed a number of issues. First, the letter advised defendant that plaintiff was represented by counsel. Second, the letter requested that defendant review its decision to deny plaintiff's claim. Third,

the letter requested a complete copy of plaintiff's file. Finally, the letter requested "any LTD [long-term disability] claim forms or other documentation that needs to be completed in order to perfect the filing of that claim." (Id.)

Plaintiff's counsel sent a second letter to defendant on January 9, 2006. (Pl. Ex. A at 52.) That letter advised defendant that plaintiff was appealing both the denial of his short-term and LTD benefits. The letter also reiterated the request for documents made in the first letter, and stated that plaintiff would file suit if the documents were not received within ten days. Plaintiff thereafter filed this suit on January 29, 2006, alleging a cause of action to recover LTD benefits. A cause of action to recover short-term disability benefits was added in the February 10, 2006 amended complaint. Plaintiff subsequently withdrew the short-term disability claim with defendant's consent, leaving only the claim to recover LTD benefits.

Plaintiff asserts he is entitled to summary judgment on the issue of whether he exhausted his administrative remedies, which ERISA requires as a prerequisite for filing a lawsuit. Specifically, plaintiff argues any failure to exhaust his administrative remedies is excused under the doctrine of futility. Defendant asserts it is entitled to summary judgment because the evidence is uncontroverted that plaintiff failed to follow the plan's procedures for filing a LTD benefits claim.

II. STANDARD OF REVIEW

Summary judgment is appropriate when, after considering the full evidentiary record, there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). When the party moving for summary judgment does not bear the ultimate burden of persuasion at trial, the burden for summary judgment may be discharged by "pointing out to the court that there is an absence of evidence to support the nonmoving party's case." Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986). The non-movant must then "make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. Id. at 322. Evidence should be viewed in the light most favorable to the nonmoving party and all inferences drawn in its favor. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). However, a mere "scintilla" of evidence will not preclude summary judgment. Id. at 252. The court's inquiry is "not whether there is literally no evidence, but whether there is any [evidence] upon which a jury could properly . . . find a verdict for the party" opposing summary judgment. Id. at 251.

III. DISCUSSION

The plan document states that the claim administrator has the authority to interpret the terms of the plan "and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan." (Pl. Ex. A at 150.) The plan document further stated that "[a]ny interpretation or

determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious."(Id.) When a plan contains such language, the United States Supreme Court and the Fourth Circuit have held the administrator's determinations can only be reviewed using an abuse of discretion standard. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Fagan v. Agreement of Sheetmetal Indus. Trust Fund, 60 F.3d 175, 179-80 (4th Cir. 1995).

The general rule is that "[a]n ERISA welfare benefit plan participant must pursue and exhaust plan remedies before gaining access to the federal courts." Gayle v. United Parcel Serv., Inc., 401 F.3d 222 (4th Cir. 2005) (citing Makara v. Health Care Corp., 872 F.2d 80, 82 (4th Cir. 1989)). The exhaustion rule requires claimants to strictly comply with the procedures provided in the plan document in asserting their administrative rights. See id. at 225-26; Hickey v. Digital Equip. Corp., 43 F.3d 941, 945-46 (4th Cir. 1995); Singer v. Black & Decker Corp., 964 F.2d 1449, 1454 (4th Cir. 1992).

The plan document in this case is clear that a claim for long-term disability benefits must have

been filed—along with "Proof"[1]—within the 90 days after plaintiff incurred a loss. (Pl. Ex. A. at 139.) Plaintiff was claiming disability as the result of a number of chronic conditions, namely chronic pancreatitis, and the medications he took to manage them. (See Pl. Ex. A at 89-90, 92-93.) Moreover, the evidence is uncontroverted that the last date plaintiff worked was February 10, 2005. (Pl. Ex. A at 1.) He stopped working at that time because of the conditions that he now attempts to claim LTD benefits for. Thus, defendant would not have acted arbitrarily or capriciously in interpreting "date of loss" to mean February 10, 2005. Cf. Doe v. Cigna Life Ins. Co. of N.Y., 304 F. Supp. 2d 477, 492-93 (W.D.N.Y. 2004).

The evidence is uncontroverted that plaintiff did not make a claim for LTD benefits before June 6, 2005—more than 90 days after the date of loss. While there is evidence and defendant concedes that plaintiff made a telephonic claim and submitted proof for short-term disability and FMLA benefits on February 18, 2005, there is no evidence that plaintiff made a telephonic claim for LTD benefits or submitted the LTD claim form and required proof within the 90-day period. Although plaintiff's doctor

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[1] "Proof" is a term defined in the plan document. "Proof" is "[w]ritten evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in the certificate. When a claim is made for any benefit described in this certificate, Proof must establish: the nature and extent of the loss or condition; Our obligation to pay the claim; and the claimant's right to receive payment." (Pl. Ex. A at 122.)

submitted a form to defendant on or about March 21, 2005, those forms did not indicate they were in reference to any LTD claim. Nor would defendant have reason to believe the form was in reference to an LTD claim because plaintiff had not yet submitted a claim form or provided telephonic notice of an LTD claim. Moreover, plaintiff's own affidavit stated that he requested and obtained the claim form from his employer during the June 6, 2005 meeting. There is no indication that he requested the form prior to that meeting. Even if he immediately completed and submitted the form at the June 6 meeting, his claim still fell outside the 90-day claim period. Because plaintiff failed to comply with the plan's claim deadline, he has not exhausted his administrative remedies and summary judgment must be granted to defendant. See Gayle v. United Parcel Serv., Inc., 401 F.3d 222, 226 (4th Cir. 2005).

It is also clear that plaintiff cannot "bootstrap" his LTD claim onto his properly made short-term disability claim. The LTD plan was separate and distinct from the short term disability plan. The LTD plan and the short-term disability plans have different plan documents, and one was covered by ERISA while the other was not. As outlined above, the uncontroverted evidence is that plaintiff did not strictly comply with the procedures outlined in the plan document for filing an LTD claim.

Plaintiff asserts the exhaustion requirement is excused in this case by the doctrine of futility. Under the doctrine of futility, a claimant is not required to exhaust administrative remedies if doing so would have been futile, which a plaintiff can

demonstrate by showing he was denied access to the procedures outlined in the plan. See Makar v. Health Care Corp. of Mid-Atlantic (Carefirst), 872 F.2d 80, 83 (4th Cir. 1989). Plaintiff argues his counsel's communications with defendant demonstrate the futility of pursuing administrative remedies in this case. Importantly, however, all of those communications occurred well after the 90-day claim period ended. Plaintiff has not offered any evidence that pursuing his administrative remedies was futile at the time he was able to file an LTD claim. Thus, plaintiff has not made a "clear and positive" showing of futility so as to excuse his failure to file a timely claim for LTD benefits. See Makar, 872 F.2d at 83.

III. CONCLUSION

Because plaintiff failed to exhaust his administrative remedies and has not demonstrated that pursuit of those remedies was futile, it is hereby **ORDERED** that plaintiff's motion for partial summary judgment be **DENIED** and defendant's motion for summary judgment be **GRANTED**.

AND IT IS SO ORDERED.

/s/_____
DAVID C. NORTON
UNITED STATES DISTRICT JUDGE

June 8, 2007
Charleston, South Carolina

ENTERED September 9, 2006

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF SOUTH CAROLINA CHARLESTON DIVISION

Jerry Isaacs	)
	)
Plaintiff,	)
	)
vs.	)
	)
Metropolitan Life Insurance Company and Robert Bosch Short Term Disability Plan	)
	)
Defendants.	)

C/A No. 2:06-288 DCN

SPECIALIZED CASE MANAGEMENT ORDER
(29 U.S.C. § 1001 *et seq.*)

This case appears to request entitlement to benefits pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.* In light of the claim for relief as set forth in the complaint (or the grounds for removal in Defendant's Notice of Removal or the defenses in Defendant's Answer), the court orders as follows:

1. Within fifteen (15) days from the date of this order, Plaintiff is required to respond to the attached Specialized Interrogatories. Defendant is required to respond to the same interrogatories within thirty (30) days after receiving Plaintiff's

Responses. **Defendant shall, at the same time, produce: (a) the governing plan document; (b) the summary plan description; and (c) the administrative record relevant to the particular claim at issue.** The responses to the interrogatories and related production are to be served on opposing counsel and are not to be filed with the court.

2. If the parties agree that all of the claims in the case are controlled or preempted by ERISA, then within fifteen (15) days after Defendant serves its Responses to the attached Specialized Interrogatories, the parties are required to confer to discuss the issues raised by the attached Joint Stipulation Instructions for ERISA Cases, **to complete the exchange of any documents on which they may rely including confirmation that the full administrative record and controlling documents have been produced, and to set a date for mediation of the action. Within one week following the conference, the parties shall file a joint certification: (a) stating the date on which they conferred; (b) advising the court of any issues raised by the Joint Stipulation on which the parties are not in agreement; (c) advising the court if either party objects to the procedure for disposition of the action proposed by the Joint Stipulation Instructions; (d) confirming that they have exchanged all documents on which either party intends to rely for resolution of the action; and (e) advising the court of the date set for mediation. The parties shall not file either the Joint Stipulation or any portion of**

the administrative record at the time of the filing of the certification. Supplementation of the record after the certification is filed with the court will not be allowed absent consent or upon showing of good cause for the delay in production.

3. In the event the parties disagree as to whether some or all of the claims in the case are controlled or preempted by ERISA, the party asserting ERISA preemption shall file, within fifteen (15) days after Defendant serves its Responses to the attached Specialized ERISA Interrogatories, a written memorandum setting forth the grounds and legal basis on which the party asserts the claims are preempted by ERISA. The form of the memorandum and the time and manner for filing any response or reply memoranda shall be governed by the provisions of Local Rule 7.00. If the court finds that some or all of the claims are preempted by ERISA, then within fifteen (15) days after such ruling, the parties are required to complete the Joint Stipulation conference outlined in Paragraph 2 above. If the court finds that some but not all of the claims are preempted by ERISA, then the parties are to propose in the Joint Stipulation how the court should proceed with any non- ERISA claims.

4. Mediation shall be completed within thirty (30) days following the conference addressed in Paragraph 2 above.

5. If the matter is not resolved by mediation, the parties shall, within sixty (60) days after the conference addressed in

Paragraph 2 above, file cross-memoranda in support of judgment with respect to all benefits claims governed by ERISA. **The Joint Stipulation shall be filed at the same time.** Each party shall have five (5) days thereafter to file an optional reply. These memoranda should follow the form of Local Rule 7.05. All references in memoranda shall be to the consecutively-numbered page of the attachments to the Joint Stipulation. In its discretion, the court may order a hearing. Unless so ordered, the court will decide the ERISA benefits issues upon the record before it without a hearing. Motions for summary judgment need not be filed. **Any party objecting to the court disposing of the case on the Joint Stipulation must file an objection with or prior to the filing of the joint certification required by Paragraph 2 of this order.**

The procedures set forth in this order are intended to supersede and replace the requirements generally applicable under Rules 26(a), (d) and (f) of the Federal Rules of Civil Procedure. This order supersedes any earlier entered scheduling order.

IT IS SO ORDERED.

/s/ _____
DAVID C. NORTON
UNITED STATES DISTRICT JUDGE

Date: September 20, 2006
Charleston, South Carolina

SPECIALIZED INTERROGATORIES TO BE ANSWERED BY THE PARTIES

1. PREEMPTION ISSUES: ERISA provides for preemption of state law claims which relate to an ERISA plan.[1] Therefore, if the plaintiff asserts any state law claims, each party should state whether it contends any of plaintiff's state law claims survive ERISA preemption. If any party contends any state law claims survive preemption, that party should set forth the factual and legal basis for this position and provide a list of any claims beyond those provided by 29 U.S.C. § 1132 which the party believes survive preemption, including claims asserted under other federal laws.

2. PERMISSIVE AMENDMENT OF PLEADING: It is this court's general policy to allow liberal amendment of the complaint to assert ERISA claims if the court finds the originally asserted claims to be preempted by ERISA. If the plaintiff asserts state law claims which are or may be

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[1] *See e.g.* 29 U.S.C. § 1002(1)-(8) (key definitions); 29 U.S.C. § 1003 (scope of coverage); 29 U.S.C. § 1144 (preemption provisions); 29 U.S.C. § 1132 (remedial provisions); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (preempting state common law for wrongful termination when plaintiff-employee alleges termination to avoid payment of pension benefits); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (preempting state law claims for breach of contract and bad faith refusal to pay benefits under an insured employee benefits plan); *Makar v. Health Care Corp. Of Mid-Atlantic*, 872 F.2d 80, 82 (4th Cir. 1989) ("After *Pilot Life*, . . .any contention that the state claims here are not preempted by ERISA would be frivolous.")

preempted, each party should state its position regarding amendment of the complaint.[2]

3. STANDARD OF REVIEW: As a general rule, this court will conduct a *de novo* review of a benefits denial decision unless the controlling plan documents grant the plan or claims administrator discretion to interpret or apply the plan's terms. An abuse of discretion standard is applied if appropriate language is included in the relevant plan documents. In the latter case, the court will also consider whether the person or entity which made the benefits denial decision had a conflict of interest.[3] Each party should explain its position regarding the appropriate standard of review in this case and, if any party contends an abuse of discretion standard applies, that party should provide the plan documentation which supports its position.

4. NON-JURY TRIAL: Although the courts are not in complete agreement, the clear majority view, which is followed by this court, is that

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[2] Plaintiff should list the claims which it would anticipate asserting under ERISA and a date by which an amended complaint will be submitted. Defendant should provide any support it may have for opposing amendment at this stage.

[3] *See Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (rejecting the "arbitrary and capricious" standard of review which was previously applied in most, if not all, circuits); *see also infra notes 6* (citing Fourth Circuit cases applying the two standards of review).

ERISA cases are to be tried non-jury.[4] If either party asserts a right to a jury trial, it should provide the factual and legal basis for its position.

5. EXHAUSTION OF PLAN REMEDIES: This court follows the general rule that a litigant must exhaust plan remedies before seeking judicial review of a plan's decision to deny benefits.[5] Each party should, therefore, state its position regarding whether plan remedies have been exhausted or whether some exception to exhaustion applies. If plan remedies have not been exhausted, each party should state its position regarding the length of time necessary to exhaust plan remedies and whether this matter should be stayed or dismissed without prejudice in the interim.

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[4] *See Biggers v. Wittek Indus. Inc.*, 4 F.3d 291, 293, 298 (4th Cir. 1993) (remanding for trial *by court* case in which state law claims were preempted by ERISA); *Berry v. CIBA-Geigy Corp.* 761 F.2d 1003, 1006-07 (4th Cir. 1985) (pre-*Firestone* case holding that ERISA cases are tried non-jury); but *see Vaughn v. Owen Steel Corp.*, 871 F. Supp. 247 (D.S.C. 1994) (allowing jury trial in at least some ERISA cases). *See generally Firestone Tire and Rubber Co. V. Bruch,* 489 U.S. 101 (1989) (not directly addressing the jury trial issue but noting that ERISA cases are guided by the principles of trust law and making numerous references to the role of the court in ERISA cases, without suggestion of any jury role).

[5] *See Hickey v. Digital Equip. Co.*, 43 F.3d 941, 945 (4th Cir. 1995) (affirming order requiring exhaustion of plan remedies absent a "clear and positive" showing of futility); *Makar v. Health Care Corp. Of Mid-America,* 872 F.2d 80, 82-83 (4th Cir. 1989) (dismissing case without prejudice because plaintiff had not exhausted available plan remedies).

6. SCOPE OF ADMISSIBLE EVIDENCE: The scope of admissible evidence is dependent to a large degree on two factors: (1) what evidence was presented to the plan during the internal review process; and (2) the applicable standard of review. See 3 and 5 above. In particular, there is a preference for limiting the plaintiff to evidence presented to the plan administrator during the internal review process.[6] If either party contends that the evidence to be considered by this court should include evidence not presented to the plan administrator during the plan's internal review process (exhaustion of plan remedies), it should provide the legal and factual basis for its position. Although the scope of discovery is broader than the scope of admissible evidence, the scope of discovery is affected by the previous two factors. Each party shall set forth its position on what discovery it intends to conduct in the case and whether the party contends discovery is limited by either the administrative record or the scope of review. No discovery shall be taken without permission of the court.

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[6] *See Sheppard & Enoch Pratt Hosp. Inc. V. Travelers Ins. Co.*, 32 F.3d 120, 124-25 (4th Cir. 1993) (when plan is granted discretion to make benefits decision, the trial court should normally refuse to consider evidence not presented to the plan); *Quesinberry v. Life Ins. Co. Of N. Am.* 987 F.2d 1017, 1025-27 (4th Cir. 1993) (discussing differing standards of review and stating preference for review limited to evidence before the administrator, especially where the administrator who made the denial decision is vested with discretion).

7. DAMAGES: This court accepts the majority view that punitive damages are not available under ERISA.[7] If the plaintiff pursues punitive damages under ERISA or under any other claims which the plaintiff contends survive preemption, the plaintiff should set forth the factual and legal basis for its position.

8. OTHER ISSUES: If the parties are aware of other procedural issues which should be addressed at this stage, they may raise them in response to this order (*e.g.*, whether the proper entities have been joined).

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[7] *See Massachusetts Mut. Ins. Co. V. Russell*, 473 U.S. 134 (1985) (integrated enforcement scheme of ERISA indicates the intent of Congress not to authorize punitive or extracontractual damages); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 424 (4th Cir. 1985) (denying extracontractual and punitive damages for denial of benefits and related harassment claims), *cert denied*, 476 U.S. 1170 (1986). ERISA does, however, allow for an award of attorney's fees. 29 U.S.C. § 1132(g); *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017, 1028-30 (4th Cir. 1993) (addressing five-factor test for award of attorneys fees under ERISA).

JOINT STIPULATION INSTRUCTIONS FOR ERISA CASES

1. Stipulate as to whether this matter involves only a claim for benefits pursuant to ERISA 29 U.S.C. § 1132(a)(1)(B) and a claim for attorney's fees pursuant to 29 U.S.C. § 1132(g). If in disagreement, state each party's position.

2. Stipulate whether administrative remedies provided by the plan have been fully exhausted. If in disagreement, state each party's position.

3. Stipulate to the standard of review and state any language of the plan that confers discretionary authority upon Defendant. The parties should specifically address the effect of any conflict of interest. If in disagreement, state each party's position and cite the language of the plan and case law that supports each position.

4. Stipulate to the contents of the administrative record and attach one copy of the relevant portions of the administrative record, consecutively numbered, as Exhibit 1. If in disagreement, attach the relevant portions of the record that are in dispute, consecutively numbered, and state each party's position.

5. Stipulate to the governing plan document(s) and attach the relevant plan document(s), consecutively numbered, as Exhibit 2. If the parties disagree as to which plan document applies, attach the relevant documents and state each party's position.

6. Stipulate to any plan provisions, exclusive of provisions that grant Defendant any discretionary authority or that outline the claims review procedure, which the court should consider in resolving this dispute. If in disagreement, state each party's position.

7. Stipulate to the substantive issues that this court should resolve. If in disagreement, state each party's position.

8 Stipulate, by signing below, that this court may dispose of this matter based upon this document, the attachments thereto, and the memoranda in support of judgment.

RESPONSES

WE SO AGREE AND STIPULATE:

_____
Counsel for Plaintiff(s)
Date:_____

_____
Counsel for Defendant(s)
Date:_____

ENTERED July 11, 2008

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 07-1549
(2:06-cv-00288-DCN)

JERRY ISAACS,

Plaintiff-Appellant

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant-Appellee

and

ROBERT BOSCH SHORT
TERM DISABILITY PLAN,

Defendant

ORDER

The Court denies the petition for rehearing and rehearing en banc. No poll was requested on the petition for rehearing en banc.

Entered at the direction of the panel: Judge Niemeyer, Judge Duncan and Judge Claude M. Hilton, Senior United States District Judge for the Eastern District of Virginia, sitting by designation.

For the Court

/s/ Patricia S. Connor, Clerk

ENTERED June 20, 2008

RECORD NO. 07-1549

In The
United States Court of Appeals
For the Fourth Circuit

JERRY ISAACS,

Plaintiff – Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant – Appellee,

ROBERT BOSCH SHORT TERM DISABILITY PLAN,

Defendant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF SOUTH CAROLINA AT CHARLESTON

PETITION FOR REHEARING WITH PETITION FOR REHEARING *EN BANC*

Robert E. Hoskins
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Counsel for Appellant

FRAP 35, 40 AND LOCAL RULE 40(b) STATEMENT

By my signature, I represent my belief that this case involves material factual and legal matters that were overlooked by the panel opinion, that the panel opinion is in conflict with decisions of other Courts of Appeal and this Honorable Court and the conflicts are not addressed in the opinion, and that the proceeding involves one or more questions of exceptional importance.

ARGUMENT AND AUTHORITIES

I) Did the District Court order imposing a blanket ban on all discovery violate Isaacs' due process rights?

Isaacs filed a second amended complaint pleading:

> "MetLife, who administers both the STD and LTD plans, denied Plaintiff's claim. Plaintiff appealed the denial, however, MetLife has failed to respond to Plaintiff's appeal and has taken longer than allowed under ERISA and, therefore, Plaintiff believes that further attempts to exhaust administrative remedies would be futile and assumes the claim is denied." (JA 11)

Two days later, the District Court issued a "Specialized Case Management Order" (hereinafter "SCMO")[1] which stated, in its introductory language:

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[1] This issue is far reaching. To the best knowledge of the undersigned, the District of South Carolina is unique in that its active (not senior) Judges, except one, employ the SCMO for ERISA cases. A copy of the order appears in the record JA 13-19. The order has been used in numerous cases. (For instance, see the District Court's decision in *Evans v. Eaton Corporation Long Term Disability Plan*, 2006 U.S. Dist. LEXIS 76322 (D.S.C. 2006), reversed and remanded by *Evans v. Eaton Corporation Long Term Disability Plan*, 514 F.3d 315 (4th Cir. 2008), where the District Court Judge noted "The parties have filed a joint stipulation and memorandum in support of judgment pursuant to the Court's specialized case management order for ERISA benefits cases." *Evans*, 2006 U.S. Dist. LEXIS 76322, *1.) (The SCMO was also used in *Donovan v. Eaton Corporation Long Term Disability Plan*, 462 F.3d 321 (4th Cir. 2006) and *Colucci v. Agfa Corporation Severance Pay Plan*, 431 F.3d 170 (4th Cir. 2005).) This court has even recognized that the handling of ERISA cases out of the District of South Carolina is unique. (See *Bynum v. Cigna Healthcare of North Carolina, Inc.*, 287 F.3d 305 (4th Cir. 2002), "While the parties' agreement to waive the summary judgment standard and submit their case to the District Court on the merits seems to be unique, the ERISA statute does not preclude such an agreement." 287 F.3d 305, fn14.) Accordingly, the order imposing a blanket prohibition on discovery is issued in nearly every single ERISA case in the District of South Carolina. To the best estimate of the undersigned, exactly 534 ERISA cases filed in the District of South Carolina since January 1, 2006 have involved the SCMO at issue here. (Estimate based upon a search on PACER using search term "ERISA" and a date restriction of cases filed after January 1, 2006. Cases assigned to Judges Houck and Wooten were excluded from the estimate because those Judges do not use the SCMO at issue and do not, generally, automatically ban discovery in ERISA cases.) The ban on discovery may not pose a problem with a straightforward benefit claim for which all administrative remedies have been exhausted and where the

> "This case appears to request entitlement to benefits pursuant to Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et. seq*. In light of the claim for relief as set forth in the complaint, . . . the court orders as follows:" (JA 13)

Thereafter, the SCMO recites specific instructions including a directive that "No discovery shall be taken without permission of the court.". (Emphasis added; JA 17) The District Court did not adjourn any hearing before issuing the blanket ban on discovery nor did the court even give the parties an opportunity to brief the issue prior to imposing the ban. Instead, the blanket bar to discovery was imposed merely because Isaacs' complaint referenced ERISA. Among various motions filed by the parties after issuance of the SCMO was "Plaintiff's Motion to Lift the Stay on Discovery". (JA 54, 55) Isaacs specifically requested "to conduct limited discovery so as to be able to address . . . the important issue of the applicability of the doctrine of futility". (JA 55) Isaacs realized that pursuant to this court's authority his burden was to demonstrate futility by "clear and convincing evidence . . .". (*Id.*) Isaacs knew he would have to compile evidence to meet his burden. Regretfully, the District Court never decided or addressed Isaacs' discovery motion.

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court is, therefore, deciding the case based upon a "neat" administrative record. However, the ban is quite a different issue in a situation, as in the matter *sub judice*, where there is not a "clean" record and there are significant procedural issues raised by the pleadings and the facts.

In his brief to this court, Isaacs again clearly raised the issue. In fact, Isaacs devoted exactly 8 pages of Appellant's brief solely to his right to do limited discovery. (Brief of Appellant, p. 46-53) Isaacs cited to numerous opinions from this court's sister circuits holding that an ERISA claimant has a right to conduct discovery regarding procedural issues. (*Id.*) In fact, every circuit (except the Tenth and this court, which has never specifically addressed the issue) has allowed an ERISA claimant to conduct discovery regarding procedural issues.[2] (See *Liston v. Unum Corp. Officers Severance Plan*, 330 F.3d 19 (1st Cir. 2003); *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163 (2nd Cir. 2001), *Pinto v. Reliance Standard Life Insurance Company*, 214 F.3d 377 (3d Cir. 2000), *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346 (5th Cir. 2004), *Wilkins v. Baptist Healthcare System, Inc., et. al.*, 150 F.3d 609 (6th Cir. 1998), *Semien v. Life Insurance Company of North America, et. al.*, 436 F.3d 805 (7th Cir. 2006), *Farley v. Arkansas Blue Cross & Blue Shield*, 147 F.3d 774 (8th Cir. 1998), *Tremain v. Bell Industries*, 196 F.3d 970 (9th Cir. 1999), and *Moon v. American Home Assurance Company*, 888 F.2d 86 (4th Cir. 1989).)

Unfortunately, the panel, like the District Court, wholly failed to address the important and far

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[2] Likewise, discovery was generally available in trust law (upon which ERISA is based; see *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. ___ (decided June 19, 2008)). See *Nagele v. E.D.S. Corp.*, 193 FRD 99, 103, 104 (W.D. NY 2000) for an excellent discussion and compilation of trust law cases and their analogy to the right to conduct discovery in an ERISA case.

reaching discovery issue. (Panel opinion, attached hereto as exhibit 1.) Accordingly, Isaacs respectfully submits that either the panel or the *en banc* court should address this important and fundamental issue.

The inability to conduct discovery on the futility issue was directly fatal to Isaacs' cause as is apparent from the panel statement:

> "Isaacs argues, in the alternative, that his failure to exhaust his administrative remedies with respect to his LTD claim should be excused because, in light of MetLife's denial of his STD claim, any attempt to pursue the LTD plan remedies would have been futile. We find that Isaacs failed to show that he was, or would have been denied access to the claims procedures provided by the LTD plan. His "bare allegations of futility are no substitute for the 'clear and positive' showing of futility . . . required before suspending the exhaustion requirement. (Citation omitted) We therefore find Isaacs' argument to be without merit." (Emphasis added; panel opinion, fn6)

Moreover, the panel affirmed the grant of summary judgment regarding the key issue of whether Isaacs had even actually filed an LTD claim by stating: ". . . the record is devoid of evidence that

any other claim was filed pursuant to the LTD plan claim procedures." (Panel opinion, p. 9)[3]

Isaacs submitted an affidavit attesting that he had completed and filled out every form that his employer or MetLife had requested of him to initiate the LTD claim. (JA 209) Further, Isaacs' counsel actually wrote MetLife two times, with no response, specifically asking whether any additional forms were needed to perfect the LTD claim. (See Brief of Appellant, pp. 11-13.) Isaacs respectfully disagrees with the panel's finding that there was no evidence he had filed an LTD claim. (In fact, at another portion of the opinion, the panel even acknowledges that there is a factual dispute regarding the forms Isaacs contends he was told were for his LTD claim. (Panel opinion, paragraph 2))

Isaacs was thrown out of court on a motion for summary judgment because he "failed to show that he was (or would have been) denied access to the

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[3] Isaacs respectfully disagrees as seen below. However, even if there was no evidence that he filed an LTD claim then summary judgment was still inappropriate because, despite the fact that the District Court and the panel failed to mention it, the LTD plan document specifies that delay in filing will not be a basis for denying an LTD claim if the lateness is reasonably excused. (See JA 194). Isaacs respectfully submits that even if his LTD claim notice was not provided until June 2005 or even November 2005 that given the "reasonableness" provision and the conflicting information given to him about his claim that he could have clearly fallen within scope of the "reasonableness" provision so that his claim would have still been considered timely even if technically late. At the very least, fact issues existed which should have precluded summary judgment given the specific language of the policy in this case.

claim procedures provided by the LTD plan" (Panel opinion, fn6) and because ". . . the record is devoid of evidence that any other claim was filed pursuant to the LTD plan claim procedures". (Emphasis added; panel opinion, p. 9) Yet, Isaacs was "handcuffed" by the blanket prohibition on discovery imposed by the SCMO and he was specifically prevented by the court from gathering the additional evidence needed to meet his burden of proof. Isaacs very respectfully submits that it is manifestly unjust and a clear denial of Isaacs' due process rights that he was denied the opportunity to do discovery on the very issues on which he requested to do so and on which this court, ultimately, found he had a failure of proof. The imposition of the blanket prohibition on discovery conflicts with the holding of every circuit court, except the Tenth, which has specifically addressed the issue (see above).

Moreover, such a blanket ban on discovery is at odds with the spirit of F.R.Civ.P. 26 (and ERISA).[4] As this court is well aware, the basic philosophy underlying discovery is that prior to trial every party to a civil action is entitled to the disclosure of all relevant information. A relevant matter encompasses anything that bears on or that reasonable could lead to information bearing on any

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[4] As recently as June 19, 2008, the United States Supreme Court, in *Metropolitan Life Ins. Co., et. al. v. Glenn*, 554 U.S. ___ (2008), reiterated the important principle that ERISA's primary purpose was "Congress desire to offer employees enhanced protection for their benefits.". *Glenn*, p. 7. Surely, arbitrarily denying plan participants all discovery rights does not protect employee benefits.

issue that is or may be in the case. *Hickman v. Taylor*, 329 U.S. 495 (1947).

The scope of discovery allowed by Rule 26(b) is broad and should be liberally construed. *Heiner v. North American Coal Corp.*, 3 FRD 63 (D.C. Pa. Hayes Little 1942). Liberal construction of the scope is to provide both parties with information essential to proper litigation on all facts. *Mallinckrodt Chemical Works v. Goldman Saxon Company*, 58 FRD 348 (S.D. NY 1973). Such is especially true when one side may have all of the facts and the ability to conceal those facts from its adversary. *Goldinger v. Boron Oil Company*, 60 FRD 562 (W.D. Pa. Hayes Little 1973). The scope of discovery is within the sound discretion of the trial court. *Miller v. Federal Express Corp.*, 186 FRD 376 (W.D. Tenn. 1999).

Importantly, in this case, the District Court never exercised any discretion and, instead, arbitrarily imposed a blanket prohibition on all discovery two days after Isaacs filed his amended complaint solely because the complaint referenced ERISA. The imposition of a wholly arbitrary and blanket bar to all discovery prevented Isaacs from obtaining the evidence that the panel now asserts he failed to provide. Isaacs very respectfully submits that the failure of the panel to even address that important issue warrants reconsideration or *en banc* review.

II) Does the panel's decision conflict with this court's precedent in *Ellis v. Metropolitan Life Insurance Company*, 126 F.3d 228 (4th Cir. 1997) and actually reward MetLife's denial of Isaacs' most fundamental rights so as to actually encourage other ERISA fiduciaries to likewise shirk their obligations in the hope of gaining a similar outcome?

There is a significant factual issue in this case as to whether Isaacs actually filed an LTD claim. It is undisputed that Isaacs actually filed a short term disability claim. That short term disability claim was denied on June 1, 2005 and

ENTERED August 1, 2007

RECORD NO. 07-1549

In The
United States Court of Appeals
For the Fourth Circuit

JERRY ISAACS,

Plaintiff – Appellant,

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant – Appellee,

ROBERT BOSCH SHORT TERM DISABILITY PLAN,

Defedant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF SOUTH CAROLINA AT CHARLESTON

BRIEF OF APPELLANT

Robert E. Hoskins
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601 East McBee Avenue, Suite 104
Post Office Box 2123
Greenville, South Carolina 29602
(864) 242-6200

Counsel for Appellant

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d. <u>The reasonableness exception to the 90 day limitation period</u>.

As discussed above, surely the issue of whether the reasonableness exception is applicable to Isaacs' case is a factual issue which should have precluded summary judgment.

Issue IV: Should the court have allowed limited discovery on relevant procedural issues?

The SCMO which is used for ERISA claims by the District Court is truly a wonderful order. It streamlines the process and facilities disposition of cases which is in the best interest of the parties, counsel and the court. The order by its terms prohibits discovery. (See JA 17, "No discovery shall be taken without permission of the court.".)

However, the SCMO is flexible enough to recognize that in some circumstances discovery will be necessary even with an ERISA benefit claim. Accordingly, the order envisions that the parties can ask the court to lift the stay on discovery. Although the undersigned does not exercise that right very often, he does so occasionally when circumstances warrant. The only time the undersigned will request permission to lift the stay on discovery is if it appears that there are procedural abnormalities that occurred during the claim process. (In fact, on every occasion (other than the matter *sub judice*) which the undersigned has asked the District Court to lift the stay to allow limited discovery regarding

procedural matters on a disability claim, the court has agreed. (For instance, see *Rice v. Eaton Corporation Short Term Disability Plan, et. al.*, 3:04-1923-MBS, *White v. Eaton Corporation Short Term Disability Plan, et. al.*, 8:04-18484-HFF, among several others. The unpublished orders of the Honorable District Court Judges Seymour and Floyd are attached as exhibits hereto respectively as 4 and 5.)

As is hopefully apparent by the factual recitation herein, Isaacs' claim did not develop normally. Because of the procedural abnormalities that existed, Isaacs filed a "motion to lift the stay on discovery". (See JA 54, 55) Isaacs only wished "to conduct limited discovery so as to be able to address any further factual inquiry that (may be) appropriate on the issue" of the doctrine of futility. Whether or not the doctrine of futility applies to a particular set of facts is, obviously, the same inquiry as whether a claimant can receive a "full and fair" review. Isaacs respectfully submits that granting MetLife's motion for summary judgment without allowing Isaacs to conduct any limited discovery regarding the review process is error.

Fed. R. Civ. P. 26(b) provides that:

> "Parties may obtain discovery, regarding any manner, not privileged, that is relevant to the claim or defense of any party . . . For good cause, the court may order discovery of any matter relevant to the subject matter involved in the action. Relevant information

> need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence."

The basic philosophy underlying discovery is that prior to trial every party to a civil action is entitled to the disclosure of all relevant information. A relevant matter encompasses anything that bears on or that reasonably could lead to information bearing on any issue that is or may be in the case. (*Hickman v. Taylor*, 329 U.S. 495 (1947).)

Generally discovery does not occur in a straightforward ERISA benefit claim case. The logic behind the discovery limitation in such cases is that the court is confined to reviewing the administrative record when the scope of review is discretionary. (See *Shepherd & Enoch Pratt Hospital v. Travelers Insurance Company*, 32 F.3d 120 (4th Cir. 1994).) It logically flows that no discovery may occur on substantive issues because whatever substantive information that might be discovered would not ultimately be admissible if it was not already in the administrative record. Accordingly, it is rare for discovery to occur with a straight ERISA benefit claim. However, in the matter *sub judice* there are unusual facts present pertaining to the review process.

The right to a "full and fair" review derives from 29 U.S.C.S. § 1133. As this court is aware, in reviewing an ERISA claim for benefits where an administrator contends that its' decision is subject to discretionary review, the court must evaluate

various factors. In *Booth v. Wal-Mart Stores, Inc.*, 201 F.3d 335 (4th Cir. 2000), the court held:

> "Combining these various criteria for determining the reasonableness of a fiduciary's discretionary decision, we conclude that a court may consider, but is not limited to, such factors as: (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and with either interpretations of the plan; (5) whether the decisionmaking process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have. n2" (Emphasis added; *Booth*, 201 F.3d at 342; see also *Colucci v. Agfa Corporation Severance Pay Plan*, 431 F.3d 170 (4th Cir. 2005).)

In *Bedrick v. Travelers Insurance Company*, 93 F.3d 149 (4th Cir. 1996), the court discussed the importance of the right to a "full and fair review" of denied claims by an "appropriate named fiduciary"." (*Bedrick*, 93 F.3d 149, 153 citing 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(g); and *Weaver v. Phoenix*

Home Life Mut. Ins. Co., 990 F.2d 154, 157 (4th Cir. 1993).) In *Bedrick*, the parties conducted rather extensive discovery through which the plaintiff learned that his insurer's review process might be a sham. As a result of the evidence procured through discovery, this court stated "In sum, we are very skeptical that the Bedricks received a "full and fair review"." (*Id.*, 93 F.3d 149, 153) Obviously, if evidence tends to show that a review process is a sham then such evidence is relevant under the *Booth* factors.

Isaacs respectfully submits that there are sufficient facts in the matter *sub judice* to raise legitimate questions about the objectivity of the claim review process. If the federal rules allow Isaacs to conduct discovery on relevant topics then it goes without saying that Isaacs should be able to conduct discovery regarding whether Isaacs received a "full and fair review" and whether further attempts to exhaust administrative remedies are futile.

Although this court has never squarely addressed the issue of whether discovery relating to procedural flaws with an ERISA administrative review process is allowable, other circuits have.

The most recent and, perhaps, most thorough opinion is from the Seventh Circuit in *Semien v. Life Insurance Company of North America*, 436 F.3d 805 (7th Cir. 2006). The *Semien* court recognized that a plan participant should be allowed, in appropriate circumstances, to conduct discovery, but required

that some sort of prima facie showing must be made. The court stated:

> "When a prima facie showing of misconduct or bias is made, or a claimant demonstrates a good faith basis to believe that limited discovery will produce such evidence, the district court should engage in a more cautious review.
>
> • • •
>
> When reviewing a plan administrator's decision in the ERISA context, the district court has significant discretion to allow or disallow discovery requests. This is a fact-specific determination and will not be overturned by this Court absent a clear abuse of discretion. . . .
>
> Decisions by plan administrators are not cloaked with the same level of authority as administrative agency determinations. *See Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000). Once an ERISA plan grants a plan administrator discretionary authority to evaluate claims, however, the plan administrator's motivations should not be questioned absent a prima facie showing of some misconduct or conflict of interest. *See Perlman*, 195 F.3d at 981-82. Absent this initial showing, the

strong warning of *Perlman* remains intact: "We have no reason to think that [a plan administrator's] benefits staff is any more 'partial' against applicants than are federal judges when deciding income-tax cases." *Perlman*, 195 F.3d at 981.

Although discovery is normally disfavored in the ERISA context, at times additional discovery is appropriate to ensure that plan administrators have not acted arbitrarily and that conflicts of interest have not contributed to an unjustifiable denial of benefits. In these exceptional cases, where a district court allows limited discovery based upon what appears to be a sustainable allegation, the district court must monitor discovery closely. In this supervisory role, the district court should employ all available tools, including the imposition of Rule 11 sanctions against those who would abuse the discovery process.

Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate. *See Burch*, 489 U.S. at 115 (a conflict of interest is a factor to be considered when reviewing a plan administrator's denial of benefits); *see also Van Boxel*, 936 F.2d at 1053 (less

deference is appropriate where a trustee's impartiality can be fairly questioned). A claimant must demonstrate two factors before limited discovery becomes appropriate. First, a claimant must identify a specific conflict of interest or instance of misconduct. Second, a claimant must make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination. *See Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 932-33 (E.D. Tenn. 2004) ("Where . . . an ERISA plaintiff comes forward with a reasonable basis to believe that this conflict of interest has solidified in conscious, concrete policies, procedures, and practices to promote the company's financial welfare at the expense of a full and fair evaluation of the plaintiff's claim for benefits, then the plaintiff should be allowed to conduct limited discovery to determine whether such policies, procedures, and practices do actually exist and, if so, to what extent they interfered with the fair review of the plaintiff's claim for benefits. This information would certainly be relevant to the Court when conducting its review of the decision to deny benefits."

Emphasis added, *Semien*, 436 F.3d 805, 814, 815."[17]

In *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000), the court held "a District Court may take evidence regarding the conflict of interest, and ways in which the conflict may have influenced the decision, and then determine whether, considering the conflict, the decision was 'arbitrary and capricious'." (*Id.* at 395)

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[17] See also *Perlman v. Swiss Bank Corporation Comprehensive Disability Protection Plan, et. al.*, 195 F.3d 975 (7th Cir. 1999) where it noted that "Courts in the majority have allowed, . . . that discovery may be appropriate to investigate a claim that the plan's administrator did not do what it said it did - - that, for example, the application was thrown in the trash rather than evaluated on the merits." (*Perlman*, 195 F.3d 975, 982.

See also *Eriksen v. Metropolitan Life Insurance Company*, 39 F. Supp. 2d 864 (E.D. Mi. 1999), where the court held that it can consider evidence outside of the record:

> "where there is a procedural challenge to the administrator's decision, such as a lack of due process afforded by the administrator or alleged bias on its part."

See also *Friess v. Reliance Standard Life Ins. Co.*, 122 F. Supp. 2d 566 (E.D. Pa. 2000), the court held:

> "While forbidden from expanding the administrative record on the historic facts that informed the administrator's decision, a district court may take evidence regarding the conflict of interest and ways in which the conflict may have influenced that decision. (Citation omitted) (*Id.* at 392)."

In *Liston v. Unum Corporation Officer Severance Plan, et. al.*, 330 F.3d 19 (1st Cir. 2003), the court was clear to point out that the ordinary ERISA discovery rules would not apply to "certain kinds of claims - - e.g., proof of corruption - - (which) may in their nature or timing take a reviewing court to materials outside the administrative record."[18]

Isaacs respectfully submits that in the matter *sub judice* a prima facie showing has been made that "there is a good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination". Isaacs did not ask the court to allow him to do "wide open" unfettered discovery. Instead, he only asked the court to allow discovery on narrow procedural issues. The district court should have lifted the stay on discovery to allow Isaacs to conduct very limited discovery he sought in light of the apparent problems with Isaacs' claim process.

CONCLUSION

For all of the foregoing reasons, Isaacs respectfully submits that the district court was in error. Clearly, the district court did not have a complete understanding

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[18] *Liston*, 330 F.3d 19, 23.

ENTERED December 5, 2006

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Jerry Isaacs,	)
	)
Plaintiff,	)
	)
vs.	)
	)
Metropolitan Life Insurance Company,	)
	)
Defendant.	)

C.A. No. 2:06-00288-DCN

MEMORANDUM IN SUPPORT OF PARTIAL MOTION FOR SUMMARY JUDGMENT OR, IN THE ALTERNATIVE, TO LIFT THE STAY ON DISCOVERY

OVERVIEW AND ISSUE

Plaintiff seeks long term disability benefits pursuant to ERISA 29 U.S.C.S. § 1132 (a)(1)(B).

This court entered its standard specialized case management order (hereinafter "SCMO") on September 20, 2006. Defense counsel has provided the administrative record and applicable plan documents as required by the SCMO (the last of the documents were provided on November 14, 2006).

After reviewing relevant documents, it is apparent to the Plaintiff that a significant issue exists regarding whether administrative remedies have been properly exhausted. Plaintiff has tried to exhaust administrative remedies, but believes that the Defendant has prevented him from doing so such that he is excused from further attempts to exhaust administrative remedies by the doctrine of futility. The foregoing is a significant issue and the court's determination will impact other important issues before the court such as the standard of review and the scope of admissible evidence. Because the issue is so fundamental, Plaintiff is compelled to file this partial motion for summary judgment or, in the alternative, to lift the stay on discovery to allow limited discovery before the parties attempt to enter into a joint stipulation

* * *

> with a straight face to the same insurance company that he was "unable to perform the material and substantial duties of any occupation." M JA (femphasis added), the eligibility standard for obtaining the waiver-of-premium benefit. The denial of the easier-to-obtain claim precluded eligibility for the more-difficult-to-prove claim.
>
> Under these circumstances, Dozier had every reason to believe that administrative review of the waiver-of-premium claim would have been

> pointless. Dozier could fairly assume that the same company would apply these two tests consistently, meaning that the denial of the one claim would foreclose eligibility for relief on the other. *See Paese v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 449 (2d Cir. 2006) (noting that "Hartford's decision that Paese was not totally disabled from his 'own occupation' necessarily implies a decision that he was not totally disabled from 'any occupation"); *Cilano v. Alstom Transp. Inc.*, No. 04-CY-6322 CJS, 2005 WL 139172, at *2-3 (W.D.N.Y. Jan. 18, 2005) ("Where as here a plaintiff has exhausted one claim but not another, he may demonstrate futility by showing that the two claims are so identical that the denial of one demonstrates, with certainty that the other will also be denied.") (internal quotation marks omitted); *cf. Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996) (holding exhaustion required despite futility argument because "[t]he two claims are not so identical that Mobil's denial of the claim for separation benefits demonstrates with certainty that it would deny the ERISA claim as well")."

Plaintiff respectfully submits that in the matter *sub judice* that Plaintiff has made as clear and unequivocal showing of futility as a plan

participant can make. Under the circumstances, it is Plaintiff's hope that based upon the undisputed facts that the court will agree and hold that further attempts to exhaust administrative remedies are futile. Should that occur then the parties can proceed to enter into a joint stipulation as required by the court's specialized case management order or otherwise arrange for disposition of the case as the court may direct. However, if the court does not agree that the facts are undisputed and give rise to a finding of futility then Plaintiff, at the very least, respectfully requests that the court lift the stay on discovery and allow Plaintiff a brief period to conduct limited discovesy

PLAINTIFF'S MOTION TO LIFT THE STAY ON DISCOVERY

Plaintiff respectfully believes that summary judgment is appropriate based upon the undisputed facts. However, if the court disagrees then Plaintiff respectfully requests the court to lift the stay on discovery. The court's specialized case management order prohibits discovery without leave of the court. (See item #6 of the specialized interrogatories to be answered by the parties, attached to the court's SCMO of September 20, 2006 stating "No discovery shall be taken without permission of the court.") Under the Federal Rules of Civil Procedure, a party is entitled to conduct discovery on any issue which may be relevant. (FRCivP 26).

Plaintiff hopes that the court agrees with Plaintiff regarding the clear and convincing

evidence of futility. However, at the very least Plaintiff respectfully asks that the court lift the stay on discovery to allow the Plaintiff to conduct limited discovery so as to be able to address any further factual inquiry that the court deem appropriate on the issue. In other words, if the court finds that there are relevant factual disputes regarding the important issue of the applicability of the doctrine of futility then both parties should have the opportunity to conduct discovery regarding those disputes. Accordingly, Plaintiff respectfully requests either that the court grant Plaintiff's partial motion for summary judgment or, at the very least, lift the stay on discovery.

/s/ Robert E. Hoskins
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Attorneys for Plaintiff

Date: December 5, 2006

Diary Review – Report

Claim # 230502188443 Name: JERRY ISAACS
Status: Declined

Clm # 23050218843 Owner Id: JC10
SSN: Di Last Wrk:

Report #: 303646 Plan: 001
Subpoint: 9270 Cov: 6200
Subcode: 0004 GM Plant:

[8WDM] - On 02/18/2005 08:54 - For 230502188443
CONCURRENT FELA CLM # FM0502180803
[8WDM] – On 02/18/2005 08:54 – For FM0502180803
CONCURRENT STD CLM # 23050218843
[8 WDM] – On 02/18/2005 08:54 – For 23050218843
CLAIM IN RESEARCH
[8 WDM] – On 02/21/2005 10:25 – For 23050218843
RESEARCH PERFORMED – RESEARCH DATA MISSING
[8WDM] – On 02/21/2005 10:25 – For 23050218843
Call-up For: [UPGT] – On 02/21/2003
Call-up Complete [UC10] – On 02/22/2005
INITIAL CLAIM TELEPHONIC 050218T00026
[8WDM] – On 02/21/2005 10:25 –
For FM0502180803
Call-up For: [UTFM] On 02/21/2005
Call-up Complete: [UC10] – On 02/22/2005
INITIAL CLAIM TELEPHONIC 050218T00026
[ACS1] – On 02/21/2005 10:44 – For 23050218843
RESEARCH TEMPLATE DCN 050221R00238
[0DIF] – On 02/22/2005 11:31 – For FM0502180803
CLAIM MOVED TO FMLA SYSTEM:
FAMILY MEMBER INFORMATION:

NAME:
RELATION TYPE:

INTAKE ABSENCE DESC: FIBROSIS OF THE PANCREAS/CHRONIC PANCREATITIS
LAST 12 MONTHS WORKED AS OF DATE: 02/10/2005
SUPERVISOR INFORMATION:
NAME: JEFF TERENHORN
EMAIL ID:
PHONE/EXT: (843) 760-7000 Extn.
FAX: ( ) -
VAR SCHED DESC:
[UC10] – On 02/22/2005 11:33 – For FM05021803
FMLA ELIG CHECKED: BE IS ELIG
UC10 – On 02/22/2005 11:41 – For 23050218843
INITIAL INTERVIEW WITH ER: JANICE WOODS, PHI 843-760-7366
VERIFIED:
DLW: JANICE EADV'D EE IS EXEMPT EE, USE WHAT EVER DAY THEY GIVE
UT: SEDENTARY

Diary Review – Report

Claim # 230502188443 Name: JERRY ISAACS
Status: Declined
[ACS1] – On 11/04/2005 10:19 – For 23050218843
Call-Up For: [UA72] – On 11/04/2005
Call-Up Complete [UA72] – On 11/11/2005
OTHER INDEX DCN 051103F0B422
[ACS1] – On 11/07/2005 13:33 – For 230502188443
Call-Up For [UA72] – On 11/07/2005
Call-Up Complete [UA72] – On 11/11/2005
OTHER INDEX DCN 051107006986
[ACS1] – On 11/08/2005 12:33 – For 230502188443
Call-Up For: [UA72] – On 11/08/2005
Call-Up Complete: [UA72] – On 11/11/2005
OTHER INDEX DCN 051107F09362
[UA72] – On 11/11/2005 07:36 – For 230502188443
SUMMARY OF OTHER DCN'S REC'D
ATTY RETAINER AND EE'S AUTH TO RELEASE INFO TO ATTY
[UA72] – On 11/11/2005 07:42 – For 230502188443
OUTGOING CORRESPONDENCE ATTY REQUEST FAXED TO LEGAL
[UH44] – ON 12/20/2005 08:25 For 230502188443
CLAIM COMMENT
ER CALLED TO SEE WHAT IS GOING ON WITH THIS CLAIM AND WHERE IT IS
ADVISED ER THAT CLAIM IS IN APPEAL PROCESS
SARAH FOSTER – BENEFIT COORDINATOR
PH: 843-760-8380
[ACS1] – On 01/10/2006 11:33 – For 230502188443
Call-Up For [UC10] – On 01/10/2006
Call-Up Complete: [UC10] – On 01/13/2006
OTHER INDEX DCN 0G0109F08661

ENTERED December 5, 2006

FOSTER LAW FIRM, L.L.P.

ROBERT E. HOSKINS
PAUL J. FOSTER, JR.

January 9, 2006

VIA FACSIMILE 1-800-230-9531

MetLife Disablility
Post Office Box 14590
Lexington, Kentucky 40511-4592

RE: Jerry Isaac
Short-Term Disability Claim
Group Robert Bosch Corporation
Claim No.: 230502188443

To Whom It May Concern:

Back on November 3, 2005 I notified MetLife that I was appealing the denial of my above referenced client's claim for long term disability benefits. For your ease of reference a copy of that letter is attached hereto as exhibit A. In the caption of my appeal letter I referenced short term disability benefits. Please be advised that I am appealing the denial of both Mr. Isaac's claim for short term disability and long term disability benefits. I wanted to clarify the foregoing in the event it was not clear.

Also, to date I have not received any documents from Metlife which are responsive to my

attached request for documents. I cannot prepare or submit any substantive documents to MetLife to be considered on review until MetLife provides me the documents which I previously requested. I want to give you one more chance to provide them before I go forward and file suit. I do not want to have to file a suit unnecessarily and it is my sincerest hope that you will abide by your obligations under E.R.I.S.A. and send me the documents as soon as possible. If I do not receive the documents in the next ten (10) days then, unfortunately, you will leave me no alternative but to assume that further attempts to exhaust administrative remedies are futile. I truly do not want to have to take the foregoing position and it is my sincerest hope that you will provide the documents I requested as soon as possible.

With kind regards, I remain

Sincerely,

Robert E. Hoskins

REH/m11
Enol.

ENTERED December 5, 2006

FOSTER LAW FIRM, L.L.P.

ROBERT E. HOSKINS
PAUL J. FOSTER, JR.

1928-1999

November 3, 2005

VIA FACSIMILE 1-800-230-9531
& U.S. Mail

MetLife Disablility
Post Office Box 14590
Lexington, Kentucky 40511-4592

RE: Jerry Isaac
Short-Term Disability Claim
Group Robert Bosch Corporation
Claim No.: 230502188443

To Whom It May Concern:

Please be advised that I have been retained to represent the above referenced individual in connection with the appeal of your denial of his claim for long term disability benefits. I am in the process of obtaining a Confirmation of Representation signed by my client and I will forward the same to you immediately upon receipt. **Please do not correspond or communicate directly with my client in any way and direct all correspondence or communication to my**

attention at the above address. The purpose of my letter is two fold.

First, I wish to notify you that we do wish a review of the denial of Mr. Isaac's claim pursuant to 29 U.S.C.S. § 1133. Although, I am requesting that you begin your review I do not wish for you to complete the review until I am able to submit to you all of Mr. Isaac's medical records. I am in the process of obtaining his medical records and, as I am sure you can appreciate, I am at the mercy of the various physicians' offices with regard to when I will receive complete copies of the records. I have already ordered the records and I hope to receive them any day now. As soon as I receive the records I will immediately forward them to you. It is absolutely essential that these records be considered as part of this review and, therefore, please do not conclude your review until I am able to submit to you complete copies of Mr. Isaac's relevant medical records.

ENTERED December 5, 2006

FOSTER LAW FIRM, L.L.P.

ROBERT E. HOSKINS
PAUL J. FOSTER, JR.

November 3, 2005

VIA FACSIMILE 1-800-230-9531
& U.S. Mail

MetLife Disablility
Post Office Box 14590
Lexington, Kentucky 40511-4592

RE: Jerry Isaac
Short-Term Disability Claim
Group Robert Bosch Corporation
Claim No.: 230502188443

To Whom It May Concern:

Please be advised that I have been retained to represent the above referenced individual in connection with the appeal of your denial of his claim for long term disability benefits. I am in the process of obtaining a Confirmation of Representation signed by my client and I will forward the same to you immediately upon receipt. **Please do not correspond or communicate directly with my client in any way and direct all correspondence or communication to my attention at the above address.** The purpose of my letter is two fold.

First, I wish to notify you that we do wish a review of the denial of Mr. Isaac's claim pursuant to 29 U.S.C.S. § 1133. Although, I am requesting that you begin your review I do not wish for you to complete the review until I am able to submit to you all of Mr. Isaac's medical records. I am in the process of obtaining his medical records and, as I am sure you can appreciate, I am at the mercy of the various physicians' offices with regard to when I will receive complete copies of the records. I have already ordered the records and I hope to receive them any day now. As soon as I receive the records I will immediately forward them to you. It is absolutely essential that ehese records be considered as part of this review and, therefore, please do not conclude your review until I am able to submit to you complete copies of Mr. Isaac's relevant medical records.

I will forward these to you in the near future.

The second purpose of my letter is to request a complete copy of each and every document upon which you have based your denial of Mr. Isaac's claim. Such documents include any medical documents, substantive documents, the plan document and any internal guidelines or regulations which your company have used in evaluating my clients claim. This request is made pursuant to 29 U.S.C.S. § 1132(c) and 29 U.S.C.S. § 1133 as interpreted by the Fourth Circuit Court of Appeals in *Ellis v. Metropolitan Life Insurance Company*, 126 F.3d 228 (4th Cir. 1997) and the newly enacted Code of Federal Regulations interpreting 29 U.S.C.S. § 1133. In this Federal Circuit, the courts require that

a beneficiary be given the documentation upon which his claim has been denied so that the beneficiary will have a full and fair opportunity to respond to the same should he deem it appropriate. I will be more than happy to pay any copying costs incurred and I would appreciate receiving any information from you in the near future so that Mr. Isaac will have an opportunity to respond to anything contained therein should he determine it appropriate.

The third purpose of this letter with regard to my clients LTD claim. My client has been out long enough to where it is time to get her LTD claim in the works. If you could please forward any LTD claim forms or other documentation that needs to be completed in order to prefect the filing of that claim I would be most appreciative. If the LTD claim rolls over automatically after payment in full of the STD benefits then please just advise and I will proceed with the STD claim since, essentially, it will be considered to be the same claim. Either way is fine with me. Please advise as to how you refer to handle the LTD claim. If there are any forms that need to be completed please send them to me.

I thank you for your consideration in this matter and should you need anything further from me please do not hesitate to contact me. I will provide to you as soon as it is possible the additional information which I wish for you to consider.

With kind regards, I remain,

Sincerely,

/s/Robert E. Hoskins

REH/m11

ENTERED December 5, 2006

Metropolitan Life Insurance Company

MetLife

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

June 1, 2005

Terry Isaac
Regarding: Short-term Disability Claim
Group: Robert Bosch Corp.
Claim No: 230502188443

Dear Mr. Isaac,

We are writing in regard to your claim for Short Term Disability Benefits under the terms of the Robert Bosch Corporation Group Plan.

Unlike the terms of your plan, weekly short-term disability benefits will be paid to you because of illness, injury, or pregnancy you cannot perform each of the material duties of your occupation. Furthermore, you are not considered disabled or under a Disability unless you are under the ongoing care and treatment of a licensed Physician, who is practicing within the scope of his/her license during the entire period of Disability.

Based upon a thorough review and evaluation of the occupational information and all the medical

documentation submitted by you and your physician, we have deteremed that you do not qualify for benefits under the Plan. The reasons for our determination will set forth below.

Your employer indicates that your last day worked as February 15, 2005. Your physician, Dr. Arlane Olaisen informed our office that she did not advise you to stop working. Dr. Arlene Olaisen stated that you were capable of performing your job duties as a Maintenance Planner Associate, therefore, your benefits have been denied.

This claim was processed in accordance with the terms of your Employee Benefit Plan.

Because your claim was denied in whole or in part, you may appeal this decision by sending a written request for appeal to MetLife Disablility, PO Box 14590, Lexington KY, 40511-4592 within 190 days after you receive this denial letter. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit any additional comments, documents, records or other information relating to your claim that you deem appropriate for us to give your appeal proper consideration. Upon request, MetLife will provide you with a copy of the documents, records, or other information we have that are relevant to your claim and identify and medical or vocational expert(s) whose advice was obtained in connection with your claim.

MetLife will evaluate all the information and advise you of our determination of your appeal

within 45 days after we receive your written request for appeal. If there are special circumstances requiring additional time to complete our review, we may take up to an additional 45 days, but only after notifying you of the special circumstances in writing.

Sincerely

/s/ Charlotte Levensallor

MetLife Disability Case Specialist
Ph# 1-800-300-4296

Disability Claim
Attending Physician Statement

MetLife
Net Disability
P.O. Box 3017
Utica, NY
13540-3017

Indicate type of claim
[] STD/Salary Continuance [] LTD
[] Unified Disability STD/LTD

The following section must be completed and signed by the employee/patient.
Any fee for the completion of this form is the patient's responsibility.

Occupation:

Name: Jerry Isaacs Social Security #:

Employer: Robert Bosch Group:

I hereby authorize my physician to release any information incurred in the course of my examination or treatment.

Signature of employee: /s/_____

Date: 4/11/05

The purpose of this report is to assist us in making a thorough determination.

Please complete all applicable sections of this form

History

Symptoms result from: []Injury [x]illness
[]pregnancy

If pregnancy, delivery date: ____[] Exposed
____[] Actual

Type of delivery: _____

Most recent date of treatment: _____

Is condition work related: []yes [x]no

Did you advise the patient to easen the above noted occupation: [] Yes [x] No If Yes, Date:_____

Names and Phone Numbers of the other providers the patient was referred to

Name: James Schenli Phone: (343) 571-0643

Name: GI- musc Phone:_____

Has patient been hospitalized? [x] Yes [] No

If Yes, Date 2/24/03 through 2/26/03
6/11/02 though 6/16/02
6/12/00 through 6/15/00

Name and address of facility
Trident Hospital, Charleston, SC

Diagnosis and Treatment

Primary ICD-8: 5771

Diagnosis: Chronic Pancreatis

Secondary ICD-8: __ _____

Diagnosis: _____

Subjective Symptoms:

Chronic abdominal pain and worse when eats

Objective Findings: (Includes copies of any x-rays, bb tests, EKG, and other notes)

Amylase and Ligase – intermittently elevated.

Current and Recommended Treatment Plans:

Duragesic Patch and pm Pecocet
Referred to consider if celiae black might be affected.

If surgery performed/anticipated, provide the following:

CPT: 47562

Procedure: Liproscopic Cholecystecicom

Date: 9/02

Medications prescribed:

Duragesic 50 mg q72h
Prevacid 30 mg bid
Leasapro 20 mg daily
Rylan 20 mg quid

Psychological Funcions

Check applicable Box Below:

[] Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
[] Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations)
[] Class 3 – Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations (moderate limitations)
[] Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations
[] Class 5 – Patient has significant loss of psychological, physiological personal and social adjustment (covers limitations)

Comments:

What stress factors or problems with interpersonal skills have influenced patients ability to perform the duties of the job?

Entered December 5, 2006

Metropolitan Life Insurance Company

MetLife

PO Box 14590, Lexington KY 40511-4590
Fax 1-800-230-9531

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Depeartment of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Instructions for completing the form:

1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

Jerry L. Issacs	_____
Name of Employee	Social Security Number
Claim Number	230502188443

Authorization to Disclose Information About Me

For purposes of determining my eligibility benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits. I permit the following disclosures of information about me to be made in the formal requested including by telephone, fax or mail.

1. I permit: any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service insurer, employer, government agency, group policy holder, contract holder or benefit plan administrator to disclose to Metroplitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its disability benefit plan, and any consumer reporting agencies, investigate agencies, attorneys, and independent claim administrators acting on Metlife's behalf, any and all information about my health, medical care, employment, and disability claim.

2. I permit: MetLife to disclose to my employer in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me specifically includes my permission to disclose my entire medical record, including medical information, records, test results,

and data on: medical care or surgey; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse, including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illness and sexually transmitted diseases or other serious communicable illness may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient is permitted or require by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

I understand that I may revoke this authorization at any time by writing to MetLife Disability at PO Box 14590. Lexington, KY 40511-459C, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is valid as the original form and I have a right to receive a copy upon request.

/s/	2-25-08
Signature of Employee	Date

ENTERED December 5, 2006

MetLife

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. PLEASE READ THIS CERTIFICATE CAREFULLY.

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	Robert Bosch Corporation
Group Policy Number	104842-G
Type of Insurance:	Disability Income Insurance: Long Term Benefits

MetLife Toll Free Number(s): For Claim Information

FOR DISABILITY INCOME CLAIMS: 1-800-653-6707

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERENED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If you are not satisfied with your Certificate, You may return It to Us within 20 days after you receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of your receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if you elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under your Certificate will not be covered.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

ENTERED December 5, 2006

* * *

other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information.

- Name of Employee
- Name of the Plan
- Reference of the initial decsion
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim.

Deference will not be given to the initial denial, and Metlife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The Person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be subordinate of the person who made the initial decision to deny your claim. If this initial denial is based in whole or on part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an

extension to when MetLife receieves the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim your appealed is being denied and references any specific Plan provisions(s) on which the denial is based. In an internal rule, protocol, guideline or other criteria indicate that such a rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA proides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrators office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclusure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person may fire you or otherwise discrimate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which

is denied or ignored, in whole or in part, you may file suit in a state of Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court.

The Court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ENTERED December 5, 2006

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Jerry Isaacs,	)
	)
Plaintiff,	)
	)
v.	)
	)
Metropolitan Life Insurance Company,	)
	)
Defendant.	)

Case No. 2:06-288-DCN

AFFIDAVIT OF JERRY ISAACS

PERSONALLY APPEARED BEFORE ME, Jerry Isaacs, who being duly sworn, deposes and states as follows:

1. This affidavit is based upon my personal knowledge of the facts contained herein.

2. On about June 6, 2005, I was called to a meeting at the Robert Bosch plant in N. Charleston. South Carolina by the head of personnel for the plan, Andy Anderson. The meeting was attended by Andy Anderson, Janice Woods and myself. I was told that I needed to file for long-term disability and I replied that I did not have the forms.

3. Janice Woods left the meeting and returned with the forms, which she stated she had copied from the internet site for Met Life and that they were the long-term disability forms. I was told to take the forms to my doctor for completion and to return the forms to them when completed. I took the forms to my doctor who completed them, faxed a copy to Met Life and returned them to me. I then took the forms back to Andy Anderson and Janice Woods, who examined them, made copies and told me that these forms were all that was needed and that I would be contacted if anything further was required (a copy of those forms is attached hereto as exhibit A). I have never received any further contact from Robert Bosch, Met Life or anyone on their behalf asking for any other forms to be completed. I have completed or have had completed every form which MetLife or any employer Robert Bosch, has ever provided me or told me I need to submit I have never been told by MetLife or Robert Bosch that I did not file an LTD claim after I submitted the forms referenced above which Janice Woods provided to me in June 2005.

/s/Jerry Isaacs
Jerry Isaacs

SWORN to me this 5th day
of December, 2006

/s/_____
Notary Public for South Carolina
My Commission Expires: 3-27-2007

ENTERED September 18, 2006

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Jerry Isaacs,	)
	)
Plaintiff,	)
vs.	)
	)
Metropolitan Life Insurance	)
Company and Robert Bosch	)
Short Term Disability Plan	)
	)
Defendants.	)

C.A. No: 2:06-00288-DCN

SECOND AMENDED COMPLAINT

The Plaintiff, complaining of the Defendant herein, would show unto this Honorable Court as follows.

I.

Plaintiff is a citizen and resident of Moncks Corner, South Carolina.

II.

Defendant Metropolitan Life Insurance Company (hereinafter "MetLife") is an insurance

company organized and existing pursuant to the laws of one of the States of the United States, and that does business in Moncks Corner, South Carolina.

III.

Defendant Robert Bosch Short Term Disability Plan is a self-funded benefit plan organized and existing pursuant to 29 U.S.C. 5 § 1132.

IV.

In this matter, Plaintiff seeks short term and long term disability benefits under an E.R.I.S.A. plan pursuant to 29 U.S.C. 5 § 1132(a)(1)(B) and this court has jurisdiction to hear this matter based upon involvement of a federal question.

V.

Until February, 2005 Plaintiff was employed with Robert Bosch Corporation and as an employee of Robert Bosch Corporation Plaintiff was provided with short term disability benefits coverage via the Defendant Robert Bosch Corporation Short Term Disability Plan and long term disability benefit coverage via a plan insured by Defendant MetLife (hereinafter collectively referred to as "disability plans".

VI.

Because of certain problems from which he suffered Plaintiff was forced to cease working and he filed a claim for disability benefits.

VII.

MetLife, who administers both STD and LTD plans, denied Plaintiff's claim. Plaintiff appealed the denial, however, MetLife has failed to respond to Plaintiff's appeal and has taken longer than allowed under E.R.I.S.A. and therefore, Plaintiff believes that further attempts to exhaust administrative remedies would be futile and assumes the claim is denied.

FOR A FIRST CAUSE OF ACTION

VIII.

Plaintiff incorporates all prior allegations, where not inconsistent, as fully set forth herein.

IX.

Plaintiff respectfully requests that this Court consider the administrative record complied in this case and declare pursuant to 29 U.S.C.S. § 1132 (a)(1)(B) that Plaintiff is entitled to the short term and long term disability benefits that he seeks from February, 2005 up until the present and into the future. Plaintiff additionally requests that the Court award him attorney's fees and costs pursuant to 29 U.S.C.S. § 1132(g).

WHEREFORE, having fully states his complaint against the Defendant. Plaintiff prays for a declaration of entitlement to the short term and long term disability benefits he seeks from February, 2005 up to the present and into the future pursuant to 29 U.S.C.S. § 1132(1)(B), attorney's fees and costs pursuant to U.S.C.S. § 1132(g), and such other and further relief as this Court deems just and proper.

/s/Robert E. Hoskins
Robert E. Hoskins, Esq.
Federal Bar #: 5144
FOSTER LAW FIRM L.L.P.
PO Box 2123
Greenville, South Carolina 29602
(864) 242-6200
(864) 233-0290(facsimile)
E-mail: rhoskins@fosterforster.com

Attorneys for Plaintiff

Date: September 18, 2006